

Representative James A. Dunnigan proposes the following substitute bill:

INSURANCE RELATED AMENDMENTS

2014 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill modifies Title 31A, Insurance Code, and other related provisions, to address the regulation of insurance.

Highlighted Provisions:

This bill:

- ▶ amends definition provisions;
- ▶ designates insurance fraud investigators as law enforcement officers;
- ▶ addresses the Insurance Department Restricted Account;
- ▶ changes the date captive insurance companies are to pay a fee;
- ▶ addresses what constitutes a qualified insurer;
- ▶ modifies requirements for plan of orderly withdrawal from writing a line of insurance;
- ▶ addresses notice requirements related to a request for a hearing;
- ▶ modifies calculations related to interest payable on life insurance proceeds;
- ▶ addresses preferred provider contract provisions;
- ▶ addresses coverage of mental health and substance use disorders;
- ▶ modifies requirements for the uniform application form and the uniform waiver of coverage form;



- 26 ▶ amends language regarding the health benefit plan on the Health Insurance
- 27 Exchange;
- 28 ▶ amends language regarding open enrollment provisions;
- 29 ▶ modifies language regarding dental and vision policies being offered on the Health
- 30 Insurance Exchange;
- 31 ▶ clarifies language related to the designated responsible licensed individual;
- 32 ▶ clarifies references to the Violent Crime Control and Law Enforcement Act;
- 33 ▶ modifies references to state of residence to home state;
- 34 ▶ addresses requirements related to licensing when a person establishes legal
- 35 residence in the state;
- 36 ▶ changes requirements related to the commissioner placing a licensee on probation;
- 37 ▶ repeals language related to a voluntarily surrendered license that is reinstated upon
- 38 completion of continuing education requirements;
- 39 ▶ modifies certain exemptions from continuing education requirements;
- 40 ▶ clarifies training period requirements;
- 41 ▶ changes a navigator license term to one year;
- 42 ▶ provides for training periods for a navigator license;
- 43 ▶ modifies continuing education requirements for a navigator;
- 44 ▶ repeals the requirement that the commissioner publish a list of professional
- 45 designations whose continuing education requirements could be used for certain
- 46 circumstances related to navigators;
- 47 ▶ modifies provisions related to inducements;
- 48 ▶ makes navigator licensees subject to unfair marketing practice restrictions;
- 49 ▶ amends definitions specific to insurance adjusters' chapter;
- 50 ▶ exempts an applicant for the crop insurance license class from certain requirements;
- 51 ▶ modifies the definition of receiver;
- 52 ▶ addresses the provisions related to the receivership court's seizure order;
- 53 ▶ amends the purpose statement, definition, and applicability and scope provisions for
- 54 the Individual, Small Employer, and Group Health Insurance Act;
- 55 ▶ addresses the surcharge for groups changing carriers;
- 56 ▶ addresses eligibility for the small employer and individual market;

- 57 ▶ modifies the provisions related to appointment of insurance producers and the
- 58 Health Insurance Exchange;
- 59 ▶ modifies Health Insurance Exchange disclosure requirements;
- 60 ▶ requires a captive insurance company, rather than an association captive insurance
- 61 company or industrial insured group, to file a specified report;
- 62 ▶ corrects a reference to a covered employee;
- 63 ▶ changes reference to a multiple coordinated policy to a master policy;
- 64 ▶ includes reference to the defined contribution arrangement market into the Defined
- 65 Contribution Risk Adjuster Act;
- 66 ▶ modifies definitions in the Small Employer Stop-Loss Insurance Act;
- 67 ▶ addresses stop-loss insurance coverage standards, stop-loss restrictions, filing
- 68 requirements, and stop-loss insurance disclosure;
- 69 ▶ modifies commissioner's rulemaking authority under the Small Employer Stop-Loss
- 70 Insurance Act; and
- 71 ▶ makes technical and conforming amendments.

72 **Money Appropriated in this Bill:**

73 None

74 **Other Special Clauses:**

75 This bill provides an effective date.

76 **Utah Code Sections Affected:**

77 AMENDS:

- 78 **31A-1-301**, as last amended by Laws of Utah 2013, Chapter 319
- 79 **31A-2-104**, as last amended by Laws of Utah 1999, Chapter 21
- 80 **31A-3-103**, as last amended by Laws of Utah 2011, Chapter 284
- 81 **31A-3-304 (Superseded 07/01/15)**, as last amended by Laws of Utah 2011, Chapter
- 82 284
- 83 **31A-3-304 (Effective 07/01/15)**, as last amended by Laws of Utah 2013, Chapter 319
- 84 **31A-4-102**, as last amended by Laws of Utah 2008, Chapter 345
- 85 **31A-4-115**, as last amended by Laws of Utah 2002, Chapter 308
- 86 **31A-8-402.3**, as last amended by Laws of Utah 2004, Chapter 329
- 87 **31A-16-103**, as last amended by Laws of Utah 2004, Chapter 2

- 88 [31A-17-607](#), as last amended by Laws of Utah 2001, Chapter 116
- 89 [31A-22-428](#), as enacted by Laws of Utah 2008, Chapter 345
- 90 [31A-22-617](#), as last amended by Laws of Utah 2013, Chapters 104 and 319
- 91 [31A-22-618.5](#), as last amended by Laws of Utah 2013, Chapter 319
- 92 [31A-22-625](#), as last amended by Laws of Utah 2012, Chapter 253
- 93 [31A-22-635](#), as last amended by Laws of Utah 2012, Chapters 253 and 279
- 94 [31A-22-721](#), as last amended by Laws of Utah 2011, Chapter 284
- 95 [31A-23a-102](#), as last amended by Laws of Utah 2013, Chapter 319
- 96 [31A-23a-104](#), as last amended by Laws of Utah 2012, Chapter 253
- 97 [31A-23a-105](#), as last amended by Laws of Utah 2013, Chapter 319
- 98 [31A-23a-108](#), as last amended by Laws of Utah 2012, Chapter 253
- 99 [31A-23a-112](#), as last amended by Laws of Utah 2008, Chapter 382
- 100 [31A-23a-113](#), as last amended by Laws of Utah 2012, Chapter 253
- 101 [31A-23a-202](#), as last amended by Laws of Utah 2013, Chapter 319
- 102 [31A-23a-203](#), as last amended by Laws of Utah 2012, Chapter 253
- 103 [31A-23a-402.5](#), as last amended by Laws of Utah 2013, Chapter 319
- 104 [31A-23b-102](#), as enacted by Laws of Utah 2013, Chapter 341
- 105 [31A-23b-202](#), as enacted by Laws of Utah 2013, Chapter 341
- 106 [31A-23b-205](#), as enacted by Laws of Utah 2013, Chapter 341
- 107 [31A-23b-206](#), as enacted by Laws of Utah 2013, Chapter 341
- 108 [31A-23b-301](#), as enacted by Laws of Utah 2013, Chapter 341
- 109 [31A-23b-402](#), as enacted by Laws of Utah 2013, Chapter 341
- 110 [31A-25-208](#), as last amended by Laws of Utah 2011, Chapter 284
- 111 [31A-25-209](#), as last amended by Laws of Utah 2008, Chapter 382
- 112 [31A-26-102](#), as last amended by Laws of Utah 2012, Chapter 151
- 113 [31A-26-206](#), as last amended by Laws of Utah 2011, Chapter 284
- 114 [31A-26-207](#), as last amended by Laws of Utah 2001, Chapter 116
- 115 [31A-26-213](#), as last amended by Laws of Utah 2011, Chapter 284
- 116 [31A-26-214](#), as last amended by Laws of Utah 2008, Chapter 382
- 117 [31A-26-214.5](#), as last amended by Laws of Utah 2009, Chapter 349
- 118 [31A-27a-102](#), as last amended by Laws of Utah 2008, Chapter 382

- 119 [31A-27a-107](#), as enacted by Laws of Utah 2007, Chapter 309
- 120 [31A-27a-201](#), as enacted by Laws of Utah 2007, Chapter 309
- 121 [31A-27a-701](#), as last amended by Laws of Utah 2011, Chapter 297
- 122 [31A-29-106](#), as last amended by Laws of Utah 2013, Chapter 319
- 123 [31A-29-111](#), as last amended by Laws of Utah 2012, Chapters 158 and 347
- 124 [31A-29-115](#), as last amended by Laws of Utah 2004, Chapter 2
- 125 [31A-30-102](#), as last amended by Laws of Utah 2009, Chapter 12
- 126 [31A-30-103](#), as last amended by Laws of Utah 2013, Chapter 168
- 127 [31A-30-104](#), as last amended by Laws of Utah 2013, Chapters 168 and 341
- 128 [31A-30-106](#), as last amended by Laws of Utah 2011, Chapter 284
- 129 [31A-30-106.7](#), as last amended by Laws of Utah 2008, Chapter 382
- 130 [31A-30-107](#), as last amended by Laws of Utah 2009, Chapter 12
- 131 [31A-30-108](#), as last amended by Laws of Utah 2011, Chapter 284
- 132 [31A-30-207](#), as last amended by Laws of Utah 2011, Second Special Session, Chapter 5
- 133 [31A-30-209](#), as last amended by Laws of Utah 2011, Chapter 400
- 134 [31A-30-211](#), as last amended by Laws of Utah 2011, Second Special Session, Chapter 5
- 135 [31A-37-501](#), as last amended by Laws of Utah 2008, Chapter 302
- 136 [31A-40-203](#), as enacted by Laws of Utah 2008, Chapter 318
- 137 [31A-40-209](#), as enacted by Laws of Utah 2008, Chapter 318
- 138 [31A-42-202](#), as last amended by Laws of Utah 2011, Chapter 400
- 139 [31A-43-102](#), as enacted by Laws of Utah 2013, Chapter 341
- 140 [31A-43-301](#), as enacted by Laws of Utah 2013, Chapter 341
- 141 [31A-43-302](#), as enacted by Laws of Utah 2013, Chapter 341
- 142 [31A-43-303](#), as enacted by Laws of Utah 2013, Chapter 341
- 143 [31A-43-304](#), as enacted by Laws of Utah 2013, Chapter 341
- 144 [53-13-103](#), as last amended by Laws of Utah 2011, Chapter 58
- 145 [63J-1-602.2](#), as last amended by Laws of Utah 2013, Chapter 338

146 REPEALS:

- 147 [31A-30-110](#), as last amended by Laws of Utah 2011, Chapters 284 and 297
- 148 [31A-30-111](#), as last amended by Laws of Utah 2002, Chapter 308

149

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

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

152 **31A-1-301. Definitions.**

153 As used in this title, unless otherwise specified:

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

156 (i) a medical condition including:

157 (A) a medical care expense; or

158 (B) the risk of disability;

159 (ii) accident; or

160 (iii) sickness.

161 (b) "Accident and health insurance":

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

163 (A) an income replacement contract;

164 (B) a health care contract;

165 (C) an expense reimbursement contract;

166 (D) a credit accident and health contract;

167 (E) a continuing care contract; and

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

169 (ii) may provide:

170 (A) hospital coverage;

171 (B) surgical coverage;

172 (C) medical coverage;

173 (D) loss of income coverage;

174 (E) prescription drug coverage;

175 (F) dental coverage; or

176 (G) vision coverage.

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

178 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
179 63G, Chapter 3, Utah Administrative Rulemaking Act.

180 (3) "Administrator" is defined in Subsection [~~(163)~~] (164).

- 181 (4) "Adult" means an individual who has attained the age of at least 18 years.
- 182 (5) "Affiliate" means a person who controls, is controlled by, or is under common
183 control with, another person. A corporation is an affiliate of another corporation, regardless of
184 ownership, if substantially the same group of individuals manage the corporations.
- 185 (6) "Agency" means:
- 186 (a) a person other than an individual, including a sole proprietorship by which an
187 individual does business under an assumed name; and
- 188 (b) an insurance organization licensed or required to be licensed under Section
189 [31A-23a-301](#), [31A-25-207](#), or [31A-26-209](#).
- 190 (7) "Alien insurer" means an insurer domiciled outside the United States.
- 191 (8) "Amendment" means an endorsement to an insurance policy or certificate.
- 192 (9) "Annuity" means an agreement to make periodical payments for a period certain or
193 over the lifetime of one or more individuals if the making or continuance of all or some of the
194 series of the payments, or the amount of the payment, is dependent upon the continuance of
195 human life.
- 196 (10) "Application" means a document:
- 197 (a) (i) completed by an applicant to provide information about the risk to be insured;
198 and
- 199 (ii) that contains information that is used by the insurer to evaluate risk and decide
200 whether to:
- 201 (A) insure the risk under:
- 202 (I) the coverage as originally offered; or
- 203 (II) a modification of the coverage as originally offered; or
- 204 (B) decline to insure the risk; or
- 205 (b) used by the insurer to gather information from the applicant before issuance of an
206 annuity contract.
- 207 (11) "Articles" or "articles of incorporation" means:
- 208 (a) the original articles;
- 209 (b) a special law;
- 210 (c) a charter;
- 211 (d) an amendment;

- 212 (e) restated articles;
- 213 (f) articles of merger or consolidation;
- 214 (g) a trust instrument;
- 215 (h) another constitutive document for a trust or other entity that is not a corporation;
- 216 and
- 217 (i) an amendment to an item listed in Subsections (11)(a) through (h).
- 218 (12) "Bail bond insurance" means a guarantee that a person will attend court when
- 219 required, up to and including surrender of the person in execution of a sentence imposed under
- 220 Subsection 77-20-7(1), as a condition to the release of that person from confinement.
- 221 (13) "Binder" is defined in Section 31A-21-102.
- 222 (14) "Blanket insurance policy" means a group policy covering a defined class of
- 223 persons:
- 224 (a) without individual underwriting or application; and
- 225 (b) that is determined by definition without designating each person covered.
- 226 (15) "Board," "board of trustees," or "board of directors" means the group of persons
- 227 with responsibility over, or management of, a corporation, however designated.
- 228 (16) "Bona fide office" means a physical office in this state:
- 229 (a) that is open to the public;
- 230 (b) that is staffed during regular business hours on regular business days; and
- 231 (c) at which the public may appear in person to obtain services.
- 232 (17) "Business entity" means:
- 233 (a) a corporation;
- 234 (b) an association;
- 235 (c) a partnership;
- 236 (d) a limited liability company;
- 237 (e) a limited liability partnership; or
- 238 (f) another legal entity.
- 239 (18) "Business of insurance" is defined in Subsection (88).
- 240 (19) "Business plan" means the information required to be supplied to the
- 241 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
- 242 when these subsections apply by reference under:

- 243 (a) Section 31A-7-201;
- 244 (b) Section 31A-8-205; or
- 245 (c) Subsection 31A-9-205(2).
- 246 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
- 247 corporation's affairs, however designated.
- 248 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a
- 249 corporation.
- 250 (21) "Captive insurance company" means:
- 251 (a) an insurer:
- 252 (i) owned by another organization; and
- 253 (ii) whose exclusive purpose is to insure risks of the parent organization and an
- 254 affiliated company; or
- 255 (b) in the case of a group or association, an insurer:
- 256 (i) owned by the insureds; and
- 257 (ii) whose exclusive purpose is to insure risks of:
- 258 (A) a member organization;
- 259 (B) a group member; or
- 260 (C) an affiliate of:
- 261 (I) a member organization; or
- 262 (II) a group member.
- 263 (22) "Casualty insurance" means liability insurance.
- 264 (23) "Certificate" means evidence of insurance given to:
- 265 (a) an insured under a group insurance policy; or
- 266 (b) a third party.
- 267 (24) "Certificate of authority" is included within the term "license."
- 268 (25) "Claim," unless the context otherwise requires, means a request or demand on an
- 269 insurer for payment of a benefit according to the terms of an insurance policy.
- 270 (26) "Claims-made coverage" means an insurance contract or provision limiting
- 271 coverage under a policy insuring against legal liability to claims that are first made against the
- 272 insured while the policy is in force.
- 273 (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance

274 commissioner.

275 (b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent
276 supervisory official of another jurisdiction.

277 (28) (a) "Continuing care insurance" means insurance that:

278 (i) provides board and lodging;

279 (ii) provides one or more of the following:

280 (A) a personal service;

281 (B) a nursing service;

282 (C) a medical service; or

283 (D) any other health-related service; and

284 (iii) provides the coverage described in this Subsection (28)(a) under an agreement
285 effective:

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

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

288 (b) Insurance is continuing care insurance regardless of whether or not the board and
289 lodging are provided at the same location as a service described in Subsection (28)(a)(ii).

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

293 (i) by contract;

294 (ii) by common management;

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

296 (iv) by a means other than those described in Subsections (29)(a)(i) through (iii).

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

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

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

304 (30) "Controlled insurer" means a licensed insurer that is either directly or indirectly

305 controlled by a producer.

306 (31) "Controlling person" means a person that directly or indirectly has the power to
307 direct or cause to be directed, the management, control, or activities of a reinsurance
308 intermediary.

309 (32) "Controlling producer" means a producer who directly or indirectly controls an
310 insurer.

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

312 (i) a corporation doing business:

313 (A) as:

314 (I) an insurance producer;

315 (II) a surplus lines producer;

316 (III) a limited line producer;

317 (IV) a consultant;

318 (V) a managing general agent;

319 (VI) a reinsurance intermediary;

320 (VII) a third party administrator; or

321 (VIII) an adjuster; and

322 (B) under:

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

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

326 (III) Chapter 26, Insurance Adjusters; or

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

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

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

331 (34) (a) "Creditable coverage" has the same meaning as provided in federal regulations
332 adopted pursuant to the Health Insurance Portability and Accountability Act.

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

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

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

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

338 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.
339 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. 109-415.

340 (35) "Credit accident and health insurance" means insurance on a debtor to provide
341 indemnity for payments coming due on a specific loan or other credit transaction while the
342 debtor has a disability.

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

345 (b) "Credit insurance" includes:

346 (i) credit accident and health insurance;

347 (ii) credit life insurance;

348 (iii) credit property insurance;

349 (iv) credit unemployment insurance;

350 (v) guaranteed automobile protection insurance;

351 (vi) involuntary unemployment insurance;

352 (vii) mortgage accident and health insurance;

353 (viii) mortgage guaranty insurance; and

354 (ix) mortgage life insurance.

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

357 (38) "Credit property insurance" means insurance:

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

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

360 (39) "Credit unemployment insurance" means insurance:

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

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

363 (i) specific loan; or

364 (ii) credit transaction.

365 (40) "Creditor" means a person, including an insured, having a claim, whether:

366 (a) matured;

- 367 (b) unmatured;
- 368 (c) liquidated;
- 369 (d) unliquidated;
- 370 (e) secured;
- 371 (f) unsecured;
- 372 (g) absolute;
- 373 (h) fixed; or
- 374 (i) contingent.

375 (41) (a) "Crop insurance" means insurance providing protection against damage to
376 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,
377 disease, or other yield-reducing conditions or perils that is:

- 378 (i) provided by the private insurance market; or
- 379 (ii) subsidized by the Federal Crop Insurance Corporation.

380 (b) "Crop insurance" includes multiperil crop insurance.

381 (42) (a) "Customer service representative" means a person that provides an insurance
382 service and insurance product information:

- 383 (i) for the customer service representative's:
 - 384 (A) producer;
 - 385 (B) surplus lines producer; or
 - 386 (C) consultant employer; and
- 387 (ii) to the customer service representative's employer's:
 - 388 (A) customer;
 - 389 (B) client; or
 - 390 (C) organization.

391 (b) A customer service representative may only operate within the scope of authority of
392 the customer service representative's producer, surplus lines producer, or consultant employer.

393 (43) "Deadline" means a final date or time:

- 394 (a) imposed by:
 - 395 (i) statute;
 - 396 (ii) rule; or
 - 397 (iii) order; and

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

399 (44) "Deemer clause" means a provision under this title under which upon the
400 occurrence of a condition precedent, the commissioner is considered to have taken a specific
401 action. If the statute so provides, a condition precedent may be the commissioner's failure to
402 take a specific action.

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

406 (46) "Department" means the Insurance Department.

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

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

410 (a) perform the duties of:

411 (i) that individual's occupation; or

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

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

415 (i) eating;

416 (ii) toileting;

417 (iii) transferring;

418 (iv) bathing; or

419 (v) dressing.

420 (49) "Disability income insurance" is defined in Subsection (79).

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

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

423 (a) is incorporated;

424 (b) is organized; or

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

426 (52) (a) "Eligible employee" means:

427 (i) an employee who:

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

- 429 (B) has a normal work week of 30 or more hours; or
430 (ii) a person described in Subsection (52)(b).
431 (b) "Eligible employee" includes, if the individual is included under a health benefit
432 plan of a small employer:
433 (i) a sole proprietor;
434 (ii) a partner in a partnership; or
435 (iii) an independent contractor.
436 (c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):
437 (i) an individual who works on a temporary or substitute basis for a small employer;
438 (ii) an employer's spouse; or
439 (iii) a dependent of an employer.
440 (53) "Employee" means an individual employed by an employer.
441 (54) "Employee benefits" means one or more benefits or services provided to:
442 (a) an employee; or
443 (b) a dependent of an employee.
444 (55) (a) "Employee welfare fund" means a fund:
445 (i) established or maintained, whether directly or through a trustee, by:
446 (A) one or more employers;
447 (B) one or more labor organizations; or
448 (C) a combination of employers and labor organizations; and
449 (ii) that provides employee benefits paid or contracted to be paid, other than income
450 from investments of the fund:
451 (A) by or on behalf of an employer doing business in this state; or
452 (B) for the benefit of a person employed in this state.
453 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax
454 revenues.
455 (56) "Endorsement" means a written agreement attached to a policy or certificate to
456 modify the policy or certificate coverage.
457 (57) "Enrollment date," with respect to a health benefit plan, means:
458 (a) the first day of coverage; or
459 (b) if there is a waiting period, the first day of the waiting period.

460 (58) (a) "Escrow" means:

461 (i) a transaction that effects the sale, transfer, encumbering, or leasing of real property,
462 when a person not a party to the transaction, and neither having nor acquiring an interest in the
463 title, performs, in accordance with the written instructions or terms of the written agreement
464 between the parties to the transaction, any of the following actions:

465 (A) the explanation, holding, or creation of a document; or

466 (B) the receipt, deposit, and disbursement of money;

467 (ii) a settlement or closing involving:

468 (A) a mobile home;

469 (B) a grazing right;

470 (C) a water right; or

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

472 (b) "Escrow" does not include:

473 (i) the following notarial acts performed by a notary within the state:

474 (A) an acknowledgment;

475 (B) a copy certification;

476 (C) jurat; and

477 (D) an oath or affirmation;

478 (ii) the receipt or delivery of a document; or

479 (iii) the receipt of money for delivery to the escrow agent.

480 (59) "Escrow agent" means an agency title insurance producer meeting the
481 requirements of Sections [31A-4-107](#), [31A-14-211](#), and [31A-23a-204](#), who is acting through an
482 individual title insurance producer licensed with an escrow subline of authority.

483 (60) (a) "Excludes" is not exhaustive and does not mean that another thing is not also
484 excluded.

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

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

489 (a) a specific physical condition;

490 (b) a specific medical procedure;

- 491 (c) a specific disease or disorder; or
- 492 (d) a specific prescription drug or class of prescription drugs.
- 493 (62) "Expense reimbursement insurance" means insurance:
- 494 (a) written to provide a payment for an expense relating to hospital confinement
- 495 resulting from illness or injury; and
- 496 (b) written:
- 497 (i) as a daily limit for a specific number of days in a hospital; and
- 498 (ii) to have a one or two day waiting period following a hospitalization.
- 499 (63) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding
- 500 a position of public or private trust.
- 501 (64) (a) "Filed" means that a filing is:
- 502 (i) submitted to the department as required by and in accordance with applicable
- 503 statute, rule, or filing order;
- 504 (ii) received by the department within the time period provided in applicable statute,
- 505 rule, or filing order; and
- 506 (iii) accompanied by the appropriate fee in accordance with:
- 507 (A) Section [31A-3-103](#); or
- 508 (B) rule.
- 509 (b) "Filed" does not include a filing that is rejected by the department because it is not
- 510 submitted in accordance with Subsection (64)(a).
- 511 (65) "Filing," when used as a noun, means an item required to be filed with the
- 512 department including:
- 513 (a) a policy;
- 514 (b) a rate;
- 515 (c) a form;
- 516 (d) a document;
- 517 (e) a plan;
- 518 (f) a manual;
- 519 (g) an application;
- 520 (h) a report;
- 521 (i) a certificate;

- 522 (j) an endorsement;
- 523 (k) an actuarial certification;
- 524 (l) a licensee annual statement;
- 525 (m) a licensee renewal application;
- 526 (n) an advertisement; or
- 527 (o) an outline of coverage.
- 528 (66) "First party insurance" means an insurance policy or contract in which the insurer
- 529 agrees to pay a claim submitted to it by the insured for the insured's losses.
- 530 (67) "Foreign insurer" means an insurer domiciled outside of this state, including an
- 531 alien insurer.
- 532 (68) (a) "Form" means one of the following prepared for general use:
- 533 (i) a policy;
- 534 (ii) a certificate;
- 535 (iii) an application;
- 536 (iv) an outline of coverage; or
- 537 (v) an endorsement.
- 538 (b) "Form" does not include a document specially prepared for use in an individual
- 539 case.
- 540 (69) "Franchise insurance" means an individual insurance policy provided through a
- 541 mass marketing arrangement involving a defined class of persons related in some way other
- 542 than through the purchase of insurance.
- 543 (70) "General lines of authority" include:
- 544 (a) the general lines of insurance in Subsection (71);
- 545 (b) title insurance under one of the following sublines of authority:
- 546 (i) search, including authority to act as a title marketing representative;
- 547 (ii) escrow, including authority to act as a title marketing representative; and
- 548 (iii) title marketing representative only;
- 549 (c) surplus lines;
- 550 (d) workers' compensation; and
- 551 (e) ~~[any other]~~ another line of insurance that the commissioner considers necessary to
- 552 recognize in the public interest.

553 (71) "General lines of insurance" include:

554 (a) accident and health;

555 (b) casualty;

556 (c) life;

557 (d) personal lines;

558 (e) property; and

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

560 (72) "Group health plan" means an employee welfare benefit plan to the extent that the

561 plan provides medical care:

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

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

564 (b) (i) directly;

565 (ii) through insurance reimbursement; or

566 (iii) through another method.

567 (73) (a) "Group insurance policy" means a policy covering a group of persons that is

568 issued:

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

570 (ii) for the benefit of a member of the group who is selected under a procedure defined

571 in:

572 (A) the policy; or

573 (B) an agreement that is collateral to the policy.

574 (b) A group insurance policy may include a member of the policyholder's family or a

575 dependent.

576 (74) "Guaranteed automobile protection insurance" means insurance offered in

577 connection with an extension of credit that pays the difference in amount between the

578 insurance settlement and the balance of the loan if the insured automobile is a total loss.

579 (75) (a) Except as provided in Subsection (75)(b), "health benefit plan" means a policy

580 or certificate that:

581 (i) provides health care insurance;

582 (ii) provides major medical expense insurance; or

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

- 584 (A) a hospital confinement indemnity; or
- 585 (B) a limited benefit plan.
- 586 (b) "Health benefit plan" does not include a policy or certificate that:
- 587 (i) provides benefits solely for:
- 588 (A) accident;
- 589 (B) dental;
- 590 (C) income replacement;
- 591 (D) long-term care;
- 592 (E) a Medicare supplement;
- 593 (F) a specified disease;
- 594 (G) vision; or
- 595 (H) a short-term limited duration; or
- 596 (ii) is offered and marketed as supplemental health insurance.
- 597 (76) "Health care" means any of the following intended for use in the diagnosis,
- 598 treatment, mitigation, or prevention of a human ailment or impairment:
- 599 (a) a professional service;
- 600 (b) a personal service;
- 601 (c) a facility;
- 602 (d) equipment;
- 603 (e) a device;
- 604 (f) supplies; or
- 605 (g) medicine.
- 606 (77) (a) "Health care insurance" or "health insurance" means insurance providing:
- 607 (i) a health care benefit; or
- 608 (ii) payment of an incurred health care expense.
- 609 (b) "Health care insurance" or "health insurance" does not include accident and health
- 610 insurance providing a benefit for:
- 611 (i) replacement of income;
- 612 (ii) short-term accident;
- 613 (iii) fixed indemnity;
- 614 (iv) credit accident and health;

- 615 (v) supplements to liability;
616 (vi) workers' compensation;
617 (vii) automobile medical payment;
618 (viii) no-fault automobile;
619 (ix) equivalent self-insurance; or
620 (x) a type of accident and health insurance coverage that is a part of or attached to
621 another type of policy.

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

624 (79) "Income replacement insurance" or "disability income insurance" means insurance
625 written to provide payments to replace income lost from accident or sickness.

626 (80) "Indemnity" means the payment of an amount to offset all or part of an insured
627 loss.

628 (81) "Independent adjuster" means an insurance adjuster required to be licensed under
629 Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

630 (82) "Independently procured insurance" means insurance procured under Section
631 31A-15-104.

632 (83) "Individual" means a natural person.

633 (84) "Inland marine insurance" includes insurance covering:

- 634 (a) property in transit on or over land;
635 (b) property in transit over water by means other than boat or ship;
636 (c) bailee liability;
637 (d) fixed transportation property such as bridges, electric transmission systems, radio
638 and television transmission towers and tunnels; and
639 (e) personal and commercial property floaters.

640 (85) "Insolvency" means that:

- 641 (a) an insurer is unable to pay its debts or meet its obligations as the debts and
642 obligations mature;
643 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
644 RBC under Subsection 31A-17-601(8)(c); or
645 (c) an insurer is determined to be hazardous under this title.

- 646 (86) (a) "Insurance" means:
- 647 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
- 648 persons to one or more other persons; or
- 649 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
- 650 group of persons that includes the person seeking to distribute that person's risk.
- 651 (b) "Insurance" includes:
- 652 (i) a risk distributing arrangement providing for compensation or replacement for
- 653 damages or loss through the provision of a service or a benefit in kind;
- 654 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a
- 655 business and not as merely incidental to a business transaction; and
- 656 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,
- 657 but with a class of persons who have agreed to share the risk.
- 658 (87) "Insurance adjuster" means a person who directs or conducts the investigation,
- 659 negotiation, or settlement of a claim under an insurance policy other than life insurance or an
- 660 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.
- 661 (88) "Insurance business" or "business of insurance" includes:
- 662 (a) providing health care insurance by an organization that is or is required to be
- 663 licensed under this title;
- 664 (b) providing a benefit to an employee in the event of a contingency not within the
- 665 control of the employee, in which the employee is entitled to the benefit as a right, which
- 666 benefit may be provided either:
- 667 (i) by a single employer or by multiple employer groups; or
- 668 (ii) through one or more trusts, associations, or other entities;
- 669 (c) providing an annuity:
- 670 (i) including an annuity issued in return for a gift; and
- 671 (ii) except an annuity provided by a person specified in Subsections [31A-22-1305\(2\)](#)
- 672 and (3);
- 673 (d) providing the characteristic services of a motor club as outlined in Subsection
- 674 (116);
- 675 (e) providing another person with insurance;
- 676 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,

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

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

679 (i) solicitation;

680 (ii) negotiation preliminary to execution;

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

682 (iv) insuring; and

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

684 the contract, including reinsurance;

685 (h) transacting or proposing a life settlement; and

686 (i) doing, or proposing to do, any business in substance equivalent to Subsections

687 (88)(a) through (h) in a manner designed to evade this title.

688 (89) "Insurance consultant" or "consultant" means a person who:

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

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

691 placed; and

692 (c) except as provided in Section [31A-23a-501](#), is not compensated directly or

693 indirectly by an insurer or producer for advice given.

694 (90) "Insurance holding company system" means a group of two or more affiliated

695 persons, at least one of whom is an insurer.

696 (91) (a) "Insurance producer" or "producer" means a person licensed or required to be

697 licensed under the laws of this state to sell, solicit, or negotiate insurance.

698 (b) (i) "Producer for the insurer" means a producer who is compensated directly or

699 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that

700 insurer.

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

702 (c) (i) "Producer for the insured" means a producer who:

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

704 (B) receives no compensation directly or indirectly from an insurer for selling,

705 soliciting, or negotiating an insurance product of that insurer to an insurance customer or

706 insured.

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

708 (92) (a) "Insured" means a person to whom or for whose benefit an insurer makes a
709 promise in an insurance policy and includes:

710 (i) a policyholder;

711 (ii) a subscriber;

712 (iii) a member; and

713 (iv) a beneficiary.

714 (b) The definition in Subsection (92)(a):

715 (i) applies only to this title; and

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

718 (93) (a) "Insurer" means a person doing an insurance business as a principal including:

719 (i) a fraternal benefit society;

720 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
721 [31A-22-1305](#)(2) and (3);

722 (iii) a motor club;

723 (iv) an employee welfare plan; and

724 (v) a person purporting or intending to do an insurance business as a principal on that
725 person's own account.

726 (b) "Insurer" does not include a governmental entity to the extent the governmental
727 entity is engaged in an activity described in Section [31A-12-107](#).

728 (94) "Interinsurance exchange" is defined in Subsection [~~(146)~~] [\(147\)](#).

729 (95) "Involuntary unemployment insurance" means insurance:

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

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

733 (i) specific loan; or

734 (ii) credit transaction.

735 (96) "Large employer," in connection with a health benefit plan, means an employer
736 who, with respect to a calendar year and to a plan year:

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

- 739 (b) employs at least two employees on the first day of the plan year.
- 740 (97) "Late enrollee," with respect to an employer health benefit plan, means an
741 individual whose enrollment is a late enrollment.
- 742 (98) "Late enrollment," with respect to an employer health benefit plan, means
743 enrollment of an individual other than:
- 744 (a) on the earliest date on which coverage can become effective for the individual
745 under the terms of the plan; or
- 746 (b) through special enrollment.
- 747 (99) (a) Except for a retainer contract or legal assistance described in Section
748 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a
749 specified legal expense.
- 750 (b) "Legal expense insurance" includes an arrangement that creates a reasonable
751 expectation of an enforceable right.
- 752 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
753 legal services incidental to other insurance coverage.
- 754 (100) (a) "Liability insurance" means insurance against liability:
- 755 (i) for death, injury, or disability of a human being, or for damage to property,
756 exclusive of the coverages under:
- 757 (A) Subsection (110) for medical malpractice insurance;
- 758 (B) Subsection (138) for professional liability insurance; and
- 759 (C) Subsection [~~(172)~~] (173) for workers' compensation insurance;
- 760 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the
761 insured who is injured, irrespective of legal liability of the insured, when issued with or
762 supplemental to insurance against legal liability for the death, injury, or disability of a human
763 being, exclusive of the coverages under:
- 764 (A) Subsection (110) for medical malpractice insurance;
- 765 (B) Subsection (138) for professional liability insurance; and
- 766 (C) Subsection [~~(172)~~] (173) for workers' compensation insurance;
- 767 (iii) for loss or damage to property resulting from an accident to or explosion of a
768 boiler, pipe, pressure container, machinery, or apparatus;
- 769 (iv) for loss or damage to property caused by:

770 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
771 (B) water entering through a leak or opening in a building; or
772 (v) for other loss or damage properly the subject of insurance not within another kind
773 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.

774 (b) "Liability insurance" includes:
775 (i) vehicle liability insurance;
776 (ii) residential dwelling liability insurance; and
777 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
778 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
779 elevator, boiler, machinery, or apparatus.

780 (101) (a) "License" means authorization issued by the commissioner to engage in an
781 activity that is part of or related to the insurance business.

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

783 (102) (a) "Life insurance" means:

784 (i) insurance on a human life; and
785 (ii) insurance pertaining to or connected with human life.

786 (b) The business of life insurance includes:

787 (i) granting a death benefit;
788 (ii) granting an annuity benefit;
789 (iii) granting an endowment benefit;
790 (iv) granting an additional benefit in the event of death by accident;
791 (v) granting an additional benefit to safeguard the policy against lapse; and
792 (vi) providing an optional method of settlement of proceeds.

793 (103) "Limited license" means a license that:

794 (a) is issued for a specific product of insurance; and
795 (b) limits an individual or agency to transact only for that product or insurance.

796 (104) "Limited line credit insurance" includes the following forms of insurance:

797 (a) credit life;
798 (b) credit accident and health;
799 (c) credit property;
800 (d) credit unemployment;

801 (e) involuntary unemployment;
802 (f) mortgage life;
803 (g) mortgage guaranty;
804 (h) mortgage accident and health;
805 (i) guaranteed automobile protection; and
806 (j) another form of insurance offered in connection with an extension of credit that:
807 (i) is limited to partially or wholly extinguishing the credit obligation; and
808 (ii) the commissioner determines by rule should be designated as a form of limited line
809 credit insurance.

810 (105) "Limited line credit insurance producer" means a person who sells, solicits, or
811 negotiates one or more forms of limited line credit insurance coverage to an individual through
812 a master, corporate, group, or individual policy.

813 (106) "Limited line insurance" includes:

814 (a) bail bond;
815 (b) limited line credit insurance;
816 (c) legal expense insurance;
817 (d) motor club insurance;
818 (e) car rental related insurance;
819 (f) travel insurance;
820 (g) crop insurance;
821 (h) self-service storage insurance;
822 (i) guaranteed asset protection waiver;
823 (j) portable electronics insurance; and
824 (k) another form of limited insurance that the commissioner determines by rule should
825 be designated a form of limited line insurance.

826 (107) "Limited lines authority" includes~~[-(a)]~~ the lines of insurance listed in
827 Subsection (106)~~[-and]~~.

828 ~~[(b) a customer service representative.]~~

829 (108) "Limited lines producer" means a person who sells, solicits, or negotiates limited
830 lines insurance.

831 (109) (a) "Long-term care insurance" means an insurance policy or rider advertised,

832 marketed, offered, or designated to provide coverage:

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

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

835 (A) expenses incurred;

836 (B) indemnity;

837 (C) prepayment; or

838 (D) another method;

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

840 (A) diagnostic;

841 (B) preventative;

842 (C) therapeutic;

843 (D) rehabilitative;

844 (E) maintenance; or

845 (F) personal care; and

846 (iv) that may be issued by:

847 (A) an insurer;

848 (B) a fraternal benefit society;

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

850 (II) a medical service corporation;

851 (D) a prepaid health plan;

852 (E) a health maintenance organization; or

853 (F) an entity similar to the entities described in Subsections (109)(a)(iv)(A) through (E)

854 to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

858 (B) a life insurance policy or rider;

859 (ii) a policy or rider that provides for payment of benefits on the basis of:

860 (A) cognitive impairment; or

861 (B) functional capacity; or

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

- 863 (c) "Long-term care insurance" does not include:
- 864 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
- 865 (ii) basic hospital expense coverage;
- 866 (iii) basic medical/surgical expense coverage;
- 867 (iv) hospital confinement indemnity coverage;
- 868 (v) major medical expense coverage;
- 869 (vi) income replacement or related asset-protection coverage;
- 870 (vii) accident only coverage;
- 871 (viii) coverage for a specified:
- 872 (A) disease; or
- 873 (B) accident;
- 874 (ix) limited benefit health coverage; or
- 875 (x) a life insurance policy that accelerates the death benefit to provide the option of a
- 876 lump sum payment:
- 877 (A) if the following are not conditioned on the receipt of long-term care:
- 878 (I) benefits; or
- 879 (II) eligibility; and
- 880 (B) the coverage is for one or more the following qualifying events:
- 881 (I) terminal illness;
- 882 (II) medical conditions requiring extraordinary medical intervention; or
- 883 (III) permanent institutional confinement.
- 884 (110) "Medical malpractice insurance" means insurance against legal liability incident
- 885 to the practice and provision of a medical service other than the practice and provision of a
- 886 dental service.
- 887 (111) "Member" means a person having membership rights in an insurance
- 888 corporation.
- 889 (112) "Minimum capital" or "minimum required capital" means the capital that must be
- 890 constantly maintained by a stock insurance corporation as required by statute.
- 891 (113) "Mortgage accident and health insurance" means insurance offered in connection
- 892 with an extension of credit that provides indemnity for payments coming due on a mortgage
- 893 while the debtor has a disability.

894 (114) "Mortgage guaranty insurance" means surety insurance under which a mortgagee
895 or other creditor is indemnified against losses caused by the default of a debtor.

896 (115) "Mortgage life insurance" means insurance on the life of a debtor in connection
897 with an extension of credit that pays if the debtor dies.

898 (116) "Motor club" means a person:

899 (a) licensed under:

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

901 (ii) Chapter 11, Motor Clubs; or

902 (iii) Chapter 14, Foreign Insurers; and

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

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

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

907 (iii) (A) trip reimbursement;

908 (B) towing services;

909 (C) emergency road services;

910 (D) stolen automobile services;

911 (E) a combination of the services listed in Subsections (116)(b)(iii)(A) through (D); or

912 (F) other services given in Subsections 31A-11-102(1)(b) through (f).

913 (117) "Mutual" means a mutual insurance corporation.

914 (118) "Network plan" means health care insurance:

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

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

919 (119) "Nonparticipating" means a plan of insurance under which the insured is not
920 entitled to receive a dividend representing a share of the surplus of the insurer.

921 (120) "Ocean marine insurance" means insurance against loss of or damage to:

922 (a) ships or hulls of ships;

923 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,
924 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia

925 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

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

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

931 (121) "Order" means an order of the commissioner.

932 (122) "Outline of coverage" means a summary that explains an accident and health
933 insurance policy.

934 (123) "Participating" means a plan of insurance under which the insured is entitled to
935 receive a dividend representing a share of the surplus of the insurer.

936 (124) "Participation," as used in a health benefit plan, means a requirement relating to
937 the minimum percentage of eligible employees that must be enrolled in relation to the total
938 number of eligible employees of an employer reduced by each eligible employee who
939 voluntarily declines coverage under the plan because the employee:

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

941 (b) receives:

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

944 (ii) another government health benefit.

945 (125) "Person" includes:

946 (a) an individual;

947 (b) a partnership;

948 (c) a corporation;

949 (d) an incorporated or unincorporated association;

950 (e) a joint stock company;

951 (f) a trust;

952 (g) a limited liability company;

953 (h) a reciprocal;

954 (i) a syndicate; or

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

956 (126) "Personal lines insurance" means property and casualty insurance coverage sold
957 for primarily noncommercial purposes to:

- 958 (a) an individual; or
- 959 (b) a family.

960 (127) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

961 (128) "Plan year" means:

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

- 963 (i) the plan document of a group health plan; or
- 964 (ii) a summary plan description of a group health plan;

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

- 967 (i) the year used to determine deductibles or limits;
- 968 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;

969 or

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

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

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

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

974 (c) in a case not described in Subsection (128)(a) or (b), the calendar year.

975 (129) (a) "Policy" means a document, including an attached endorsement or application

976 that:

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

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

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

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

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

982 (iii) a corporation licensed under:

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

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

985 (c) "Policy" does not include:

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

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

988 (130) "Policyholder" means a person who controls a policy, binder, or oral contract by
989 ownership, premium payment, or otherwise.

990 (131) "Policy illustration" means a presentation or depiction that includes
991 nonguaranteed elements of a policy of life insurance over a period of years.

992 (132) "Policy summary" means a synopsis describing the elements of a life insurance
993 policy.

994 (133) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No.
995 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
996 related federal regulations and guidance.

997 (134) "Preexisting condition," with respect to a health benefit plan:

998 (a) means a condition that was present before the effective date of coverage, whether or
999 not medical advice, diagnosis, care, or treatment was recommended or received before that day,
1000 and

1001 (b) does not include a condition indicated by genetic information unless an actual
1002 diagnosis of the condition by a physician has been made.

1003 (135) (a) "Premium" means the monetary consideration for an insurance policy.

1004 (b) "Premium" includes, however designated:

1005 (i) an assessment;

1006 (ii) a membership fee;

1007 (iii) a required contribution; or

1008 (iv) monetary consideration.

1009 (c) (i) "Premium" does not include consideration paid to a third party administrator for
1010 the third party administrator's services.

1011 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for
1012 insurance on the risks administered by the third party administrator.

1013 (136) "Principal officers" for a corporation means the officers designated under
1014 Subsection [31A-5-203\(3\)](#).

1015 (137) "Proceeding" includes an action or special statutory proceeding.

1016 (138) "Professional liability insurance" means insurance against legal liability incident
1017 to the practice of a profession and provision of a professional service.

1018 (139) (a) Except as provided in Subsection (139)(b), "property insurance" means
1019 insurance against loss or damage to real or personal property of every kind and any interest in
1020 that property:

1021 (i) from all hazards or causes; and

1022 (ii) against loss consequential upon the loss or damage including vehicle
1023 comprehensive and vehicle physical damage coverages.

1024 (b) "Property insurance" does not include:

1025 (i) inland marine insurance; and

1026 (ii) ocean marine insurance.

1027 (140) "Qualified long-term care insurance contract" or "federally tax qualified
1028 long-term care insurance contract" means:

1029 (a) an individual or group insurance contract that meets the requirements of Section
1030 7702B(b), Internal Revenue Code; or

1031 (b) the portion of a life insurance contract that provides long-term care insurance:

1032 (i) (A) by rider; or

1033 (B) as a part of the contract; and

1034 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue
1035 Code.

1036 (141) "Qualified United States financial institution" means an institution that:

1037 (a) is:

1038 (i) organized under the laws of the United States or any state; or

1039 (ii) in the case of a United States office of a foreign banking organization, licensed
1040 under the laws of the United States or any state;

1041 (b) is regulated, supervised, and examined by a United States federal or state authority
1042 having regulatory authority over a bank or trust company; and

1043 (c) meets the standards of financial condition and standing that are considered
1044 necessary and appropriate to regulate the quality of a financial institution whose letters of credit
1045 will be acceptable to the commissioner as determined by:

1046 (i) the commissioner by rule; or

1047 (ii) the Securities Valuation Office of the National Association of Insurance
1048 Commissioners.

1049 (142) (a) "Rate" means:
1050 (i) the cost of a given unit of insurance; or
1051 (ii) for property or casualty insurance, that cost of insurance per exposure unit either
1052 expressed as:
1053 (A) a single number; or
1054 (B) a pure premium rate, adjusted before the application of individual risk variations
1055 based on loss or expense considerations to account for the treatment of:
1056 (I) expenses;
1057 (II) profit; and
1058 (III) individual insurer variation in loss experience.
1059 (b) "Rate" does not include a minimum premium.
1060 (143) (a) Except as provided in Subsection (143)(b), "rate service organization" means
1061 a person who assists an insurer in rate making or filing by:
1062 (i) collecting, compiling, and furnishing loss or expense statistics;
1063 (ii) recommending, making, or filing rates or supplementary rate information; or
1064 (iii) advising about rate questions, except as an attorney giving legal advice.
1065 (b) "Rate service organization" does not mean:
1066 (i) an employee of an insurer;
1067 (ii) a single insurer or group of insurers under common control;
1068 (iii) a joint underwriting group; or
1069 (iv) an individual serving as an actuarial or legal consultant.
1070 (144) "Rating manual" means any of the following used to determine initial and
1071 renewal policy premiums:
1072 (a) a manual of rates;
1073 (b) a classification;
1074 (c) a rate-related underwriting rule; and
1075 (d) a rating formula that describes steps, policies, and procedures for determining
1076 initial and renewal policy premiums.
1077 (145) "Rebate" means to refund or return a portion of the premium from the premium
1078 paid, commission paid, or consultant fee paid, directly or indirectly, on the sale or renewal of
1079 an insurance policy.

1080 [~~(145)~~] (146) "Received by the department" means:

1081 (a) the date delivered to and stamped received by the department, if delivered in
1082 person;

1083 (b) the post mark date, if delivered by mail;

1084 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;

1085 (d) the received date recorded on an item delivered, if delivered by:

1086 (i) facsimile;

1087 (ii) email; or

1088 (iii) another electronic method; or

1089 (e) a date specified in:

1090 (i) a statute;

1091 (ii) a rule; or

1092 (iii) an order.

1093 [~~(146)~~] (147) "Reciprocal" or "interinsurance exchange" means an unincorporated
1094 association of persons:

1095 (a) operating through an attorney-in-fact common to all of the persons; and

1096 (b) exchanging insurance contracts with one another that provide insurance coverage
1097 on each other.

1098 [~~(147)~~] (148) "Reinsurance" means an insurance transaction where an insurer, for
1099 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1100 reinsurance transactions, this title sometimes refers to:

1101 (a) the insurer transferring the risk as the "ceding insurer"; and

1102 (b) the insurer assuming the risk as the:

1103 (i) "assuming insurer"; or

1104 (ii) "assuming reinsurer."

1105 [~~(148)~~] (149) "Reinsurer" means a person licensed in this state as an insurer with the
1106 authority to assume reinsurance.

1107 [~~(149)~~] (150) "Residential dwelling liability insurance" means insurance against
1108 liability resulting from or incident to the ownership, maintenance, or use of a residential
1109 dwelling that is a detached single family residence or multifamily residence up to four units.

1110 [~~(150)~~] (151) (a) "Retrocession" means reinsurance with another insurer of a liability

- 1111 assumed under a reinsurance contract.
- 1112 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a
- 1113 liability assumed under a reinsurance contract.
- 1114 [~~(151)~~] (152) "Rider" means an endorsement to:
- 1115 (a) an insurance policy; or
- 1116 (b) an insurance certificate.
- 1117 [~~(152)~~] (153) (a) "Security" means a:
- 1118 (i) note;
- 1119 (ii) stock;
- 1120 (iii) bond;
- 1121 (iv) debenture;
- 1122 (v) evidence of indebtedness;
- 1123 (vi) certificate of interest or participation in a profit-sharing agreement;
- 1124 (vii) collateral-trust certificate;
- 1125 (viii) preorganization certificate or subscription;
- 1126 (ix) transferable share;
- 1127 (x) investment contract;
- 1128 (xi) voting trust certificate;
- 1129 (xii) certificate of deposit for a security;
- 1130 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
- 1131 payments out of production under such a title or lease;
- 1132 (xiv) commodity contract or commodity option;
- 1133 (xv) certificate of interest or participation in, temporary or interim certificate for,
- 1134 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
- 1135 in Subsections [~~(152)~~] (153)(a)(i) through (xiv); or
- 1136 (xvi) another interest or instrument commonly known as a security.
- 1137 (b) "Security" does not include:
- 1138 (i) any of the following under which an insurance company promises to pay money in a
- 1139 specific lump sum or periodically for life or some other specified period:
- 1140 (A) insurance;
- 1141 (B) an endowment policy; or

1142 (C) an annuity contract; or
1143 (ii) a burial certificate or burial contract.
1144 ~~[(153)]~~ (154) "Secondary medical condition" means a complication related to an
1145 exclusion from coverage in accident and health insurance.
1146 ~~[(154)]~~ (155) (a) "Self-insurance" means an arrangement under which a person
1147 provides for spreading its own risks by a systematic plan.
1148 (b) Except as provided in this Subsection ~~[(154)]~~ (155), "self-insurance" does not
1149 include an arrangement under which a number of persons spread their risks among themselves.
1150 (c) "Self-insurance" includes:
1151 (i) an arrangement by which a governmental entity undertakes to indemnify an
1152 employee for liability arising out of the employee's employment; and
1153 (ii) an arrangement by which a person with a managed program of self-insurance and
1154 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
1155 employees for liability or risk that is related to the relationship or employment.
1156 (d) "Self-insurance" does not include an arrangement with an independent contractor.
1157 ~~[(155)]~~ (156) "Sell" means to exchange a contract of insurance:
1158 (a) by any means;
1159 (b) for money or its equivalent; and
1160 (c) on behalf of an insurance company.
1161 ~~[(156)]~~ (157) "Short-term care insurance" means an insurance policy or rider
1162 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care
1163 insurance, but that provides coverage for less than 12 consecutive months for each covered
1164 person.
1165 ~~[(157)]~~ (158) "Significant break in coverage" means a period of 63 consecutive days
1166 during each of which an individual does not have creditable coverage.
1167 ~~[(158)]~~ (159) "Small employer[;]" means, in connection with a health benefit plan[;
1168 ~~means an employer who;~~ and with respect to a calendar year and to a plan year, an employer
1169 who:
1170 (a) employed ~~[an average of]~~ at least ~~[two employees]~~ one employee but not more than
1171 an average of 50 eligible employees on ~~[each]~~ business ~~[day]~~ days during the preceding
1172 calendar year; and

- 1173 (b) employs at least [~~two employees~~] one employee on the first day of the plan year.
- 1174 [~~(159)~~] (160) "Special enrollment period," in connection with a health benefit plan, has
- 1175 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance
- 1176 Portability and Accountability Act.
- 1177 [~~(160)~~] (161) (a) "Subsidiary" of a person means an affiliate controlled by that person
- 1178 either directly or indirectly through one or more affiliates or intermediaries.
- 1179 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
- 1180 shares are owned by that person either alone or with its affiliates, except for the minimum
- 1181 number of shares the law of the subsidiary's domicile requires to be owned by directors or
- 1182 others.
- 1183 [~~(161)~~] (162) Subject to Subsection (86)(b), "surety insurance" includes:
- 1184 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or
- 1185 perform the principal's obligations to a creditor or other obligee;
- 1186 (b) bail bond insurance; and
- 1187 (c) fidelity insurance.
- 1188 [~~(162)~~] (163) (a) "Surplus" means the excess of assets over the sum of paid-in capital
- 1189 and liabilities.
- 1190 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is
- 1191 designated by the insurer or organization as permanent.
- 1192 (ii) Sections [31A-5-211](#), [31A-7-201](#), [31A-8-209](#), [31A-9-209](#), and [31A-14-205](#) require
- 1193 that insurers or organizations doing business in this state maintain specified minimum levels of
- 1194 permanent surplus.
- 1195 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the
- 1196 same as the minimum required capital requirement that applies to stock insurers.
- 1197 (c) "Excess surplus" means:
- 1198 (i) for a life insurer, accident and health insurer, health organization, or property and
- 1199 casualty insurer as defined in Section [31A-17-601](#), the lesser of:
- 1200 (A) that amount of an insurer's or health organization's total adjusted capital that
- 1201 exceeds the product of:
- 1202 (I) 2.5; and
- 1203 (II) the sum of the insurer's or health organization's minimum capital or permanent

1204 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
1205 (B) that amount of an insurer's or health organization's total adjusted capital that
1206 exceeds the product of:
1207 (I) 3.0; and
1208 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and
1209 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer
1210 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1211 (A) 1.5; and
1212 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1213 [~~163~~] (164) "Third party administrator" or "administrator" means a person who
1214 collects charges or premiums from, or who, for consideration, adjusts or settles claims of
1215 residents of the state in connection with insurance coverage, annuities, or service insurance
1216 coverage, except:
1217 (a) a union on behalf of its members;
1218 (b) a person administering a:
1219 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1220 1974;
1221 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1222 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1223 (c) an employer on behalf of the employer's employees or the employees of one or
1224 more of the subsidiary or affiliated corporations of the employer;
1225 (d) an insurer licensed under the following, but only for a line of insurance for which
1226 the insurer holds a license in this state:
1227 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1228 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;
1229 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
1230 (iv) Chapter 9, Insurance Fraternal; or
1231 (v) Chapter 14, Foreign Insurers;
1232 (e) a person:
1233 (i) licensed or exempt from licensing under:
1234 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and

1235 Reinsurance Intermediaries; or
1236 (B) Chapter 26, Insurance Adjusters; and
1237 (ii) whose activities are limited to those authorized under the license the person holds
1238 or for which the person is exempt; or
1239 (f) an institution, bank, or financial institution:
1240 (i) that is:
1241 (A) an institution whose deposits and accounts are to any extent insured by a federal
1242 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
1243 Credit Union Administration; or
1244 (B) a bank or other financial institution that is subject to supervision or examination by
1245 a federal or state banking authority; and
1246 (ii) that does not adjust claims without a third party administrator license.
1247 [~~164~~] (165) "Title insurance" means the insuring, guaranteeing, or indemnifying of an
1248 owner of real or personal property or the holder of liens or encumbrances on that property, or
1249 others interested in the property against loss or damage suffered by reason of liens or
1250 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
1251 or unenforceability of any liens or encumbrances on the property.
1252 [~~165~~] (166) "Total adjusted capital" means the sum of an insurer's or health
1253 organization's statutory capital and surplus as determined in accordance with:
1254 (a) the statutory accounting applicable to the annual financial statements required to be
1255 filed under Section 31A-4-113; and
1256 (b) another item provided by the RBC instructions, as RBC instructions is defined in
1257 Section 31A-17-601.
1258 [~~166~~] (167) (a) "Trustee" means "director" when referring to the board of directors of
1259 a corporation.
1260 (b) "Trustee," when used in reference to an employee welfare fund, means an
1261 individual, firm, association, organization, joint stock company, or corporation, whether acting
1262 individually or jointly and whether designated by that name or any other, that is charged with
1263 or has the overall management of an employee welfare fund.
1264 [~~167~~] (168) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted
1265 insurer" means an insurer:

1266 (i) not holding a valid certificate of authority to do an insurance business in this state;

1267 or

1268 (ii) transacting business not authorized by a valid certificate.

1269 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1270 (i) holding a valid certificate of authority to do an insurance business in this state; and

1271 (ii) transacting business as authorized by a valid certificate.

1272 [~~(168)~~] (169) "Underwrite" means the authority to accept or reject risk on behalf of the
1273 insurer.

1274 [~~(169)~~] (170) "Vehicle liability insurance" means insurance against liability resulting
1275 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a
1276 vehicle comprehensive or vehicle physical damage coverage under Subsection (139).

1277 [~~(170)~~] (171) "Voting security" means a security with voting rights, and includes a
1278 security convertible into a security with a voting right associated with the security.

1279 [~~(171)~~] (172) "Waiting period" for a health benefit plan means the period that must
1280 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of
1281 the health benefit plan, can become effective.

1282 [~~(172)~~] (173) "Workers' compensation insurance" means:

1283 (a) insurance for indemnification of an employer against liability for compensation
1284 based on:

1285 (i) a compensable accidental injury; and

1286 (ii) occupational disease disability;

1287 (b) employer's liability insurance incidental to workers' compensation insurance and
1288 written in connection with workers' compensation insurance; and

1289 (c) insurance assuring to a person entitled to workers' compensation benefits the
1290 compensation provided by law.

1291 Section 2. Section **31A-2-104** is amended to read:

1292 **31A-2-104. Other employees -- Insurance fraud investigators.**

1293 (1) The department shall employ a chief examiner and such other professional,
1294 technical, and clerical employees as necessary to carry out the duties of the department.

1295 (2) An insurance fraud investigator employed pursuant to Subsection (1) may as
1296 approved by the commissioner:

1297 (a) be designated a ~~[special function]~~ law enforcement officer, as defined in Section
1298 ~~[53-13-105, by the commissioner, but is not]~~ 53-13-103; and

1299 (b) be eligible for retirement benefits under the Public Safety Employee's Retirement
1300 System.

1301 Section 3. Section **31A-3-103** is amended to read:

1302 **31A-3-103. Fees.**

1303 (1) For purposes of this section, "services" means functions that are reasonable and
1304 necessary to enable the commissioner to perform the duties imposed by this title including:

1305 (a) issuing or renewing a license or certificate of authority;

1306 (b) filing a policy form;

1307 (c) reporting a producer appointment or termination; and

1308 (d) filing an annual statement.

1309 (2) Except as otherwise provided by this title:

1310 (a) the commissioner may set and collect a fee for services provided by the
1311 commissioner;

1312 (b) a fee related to the renewal of a license may be imposed no more frequently than
1313 once each year; and

1314 (c) a fee charged by the commissioner shall be set in accordance with Section
1315 63J-1-504.

1316 (3) (a) The commissioner shall publish a schedule of fees established pursuant to this
1317 section.

1318 (b) The commissioner shall, by rule, establish the deadlines for payment of a fee
1319 established pursuant to this section.

1320 (4) (a) ~~[Beginning July 1, 2011, there]~~ There is created in the General Fund a restricted
1321 account known as the "Insurance Department Restricted Account."

1322 (b) Except as provided in Subsection (4)(c), the Insurance Department Restricted
1323 Account shall consist of:

1324 (i) fees authorized by this section; and

1325 (ii) other money received by the department, including:

1326 (A) reimbursements for examination costs incurred by the department; and

1327 (B) forfeitures collected under this title.

1328 (c) The department shall deposit money it receives that is subject to a restricted account
1329 or enterprise fund created by this title into the restricted account or enterprise fund in
1330 accordance with the statute creating the restricted account or enterprise fund, and the
1331 department may not deposit the money into the Insurance Department Restricted Account.

1332 (d) Subject to appropriation by the Legislature, the department may expend money in
1333 the Insurance Department Restricted Account to fund the operations of the department.

1334 (e) (i) At the end of each fiscal year until June 30, 2015, the director of the Division of
1335 Finance shall transfer into the General Fund any money deposited into the Insurance
1336 Department Restricted Account under Subsection (4)(b) that exceeds the legislative
1337 appropriations from the Insurance Department Restricted Account for that year.

1338 (ii) Beginning with fiscal year 2015-2016, an appropriation of the Insurance
1339 Department Restricted Account is nonlapsing, except that at the end of each fiscal year, money
1340 received by the commissioner in excess of \$8,500,000 shall be treated as free revenue in the
1341 General Fund.

1342 Section 4. Section **31A-3-304 (Superseded 07/01/15)** is amended to read:

1343 **31A-3-304 (Superseded 07/01/15). Annual fees -- Other taxes or fees prohibited --**
1344 **Captive Insurance Restricted Account.**

1345 (1) (a) A captive insurance company shall pay an annual fee imposed under this section
1346 to obtain or renew a certificate of authority.

1347 (b) The commissioner shall:

1348 (i) determine the annual fee pursuant to Section [31A-3-103](#); and

1349 (ii) consider whether the annual fee is competitive with fees imposed by other states on
1350 captive insurance companies.

1351 (2) A captive insurance company that fails to pay the fee required by this section is
1352 subject to the relevant sanctions of this title.

1353 (3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter
1354 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under
1355 the laws of this state that may be levied or assessed on a captive insurance company:

1356 (i) a fee under this section;

1357 (ii) a fee under Chapter 37, Captive Insurance Companies Act; and

1358 (iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company

1359 Act.

1360 (b) The state or a county, city, or town within the state may not levy or collect an
1361 occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii)
1362 against a captive insurance company.

1363 (c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115
1364 against a captive insurance company.

1365 (d) A captive insurance company is subject to real and personal property taxes.

1366 (4) A captive insurance company shall pay the fee imposed by this section to the
1367 commissioner by June [~~20~~] 1 of each year.

1368 (5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be
1369 deposited into the Captive Insurance Restricted Account.

1370 (b) There is created in the General Fund a restricted account known as the "Captive
1371 Insurance Restricted Account."

1372 (c) The Captive Insurance Restricted Account shall consist of the fees described in
1373 Subsection (3)(a).

1374 (d) The commissioner shall administer the Captive Insurance Restricted Account.
1375 Subject to appropriations by the Legislature, the commissioner shall use the money deposited
1376 into the Captive Insurance Restricted Account to:

1377 (i) administer and enforce:

1378 (A) Chapter 37, Captive Insurance Companies Act; and

1379 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and

1380 (ii) promote the captive insurance industry in Utah.

1381 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,
1382 except that at the end of each fiscal year, money received by the commissioner in excess of
1383 \$950,000 shall be treated as free revenue in the General Fund.

1384 Section 5. Section 31A-3-304 (Effective 07/01/15) is amended to read:

1385 **31A-3-304 (Effective 07/01/15). Annual fees -- Other taxes or fees prohibited --**
1386 **Captive Insurance Restricted Account.**

1387 (1) (a) A captive insurance company shall pay an annual fee imposed under this section
1388 to obtain or renew a certificate of authority.

1389 (b) The commissioner shall:

- 1390 (i) determine the annual fee pursuant to Section 31A-3-103; and
1391 (ii) consider whether the annual fee is competitive with fees imposed by other states on
1392 captive insurance companies.
- 1393 (2) A captive insurance company that fails to pay the fee required by this section is
1394 subject to the relevant sanctions of this title.
- 1395 (3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter
1396 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under
1397 the laws of this state that may be levied or assessed on a captive insurance company:
- 1398 (i) a fee under this section;
1399 (ii) a fee under Chapter 37, Captive Insurance Companies Act; and
1400 (iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company
1401 Act.
- 1402 (b) The state or a county, city, or town within the state may not levy or collect an
1403 occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii)
1404 against a captive insurance company.
- 1405 (c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115
1406 against a captive insurance company.
- 1407 (d) A captive insurance company is subject to real and personal property taxes.
- 1408 (4) A captive insurance company shall pay the fee imposed by this section to the
1409 commissioner by June [~~20~~] 1 of each year.
- 1410 (5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be
1411 deposited into the Captive Insurance Restricted Account.
- 1412 (b) There is created in the General Fund a restricted account known as the "Captive
1413 Insurance Restricted Account."
- 1414 (c) The Captive Insurance Restricted Account shall consist of the fees described in
1415 Subsection (3)(a).
- 1416 (d) The commissioner shall administer the Captive Insurance Restricted Account.
1417 Subject to appropriations by the Legislature, the commissioner shall use the money deposited
1418 into the Captive Insurance Restricted Account to:
- 1419 (i) administer and enforce:
1420 (A) Chapter 37, Captive Insurance Companies Act; and

1421 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and
1422 (ii) promote the captive insurance industry in Utah.
1423 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,
1424 except that at the end of each fiscal year, money received by the commissioner in excess of
1425 \$1,250,000 shall be treated as free revenue in the General Fund.

1426 Section 6. Section **31A-4-102** is amended to read:

1427 **31A-4-102. Qualified insurers.**

1428 (1) A person may not conduct an insurance business in Utah in person, through an
1429 agent, through a broker, through the mail, or through another method of communication,
1430 except:

1431 (a) an insurer:

1432 (i) authorized to do business in Utah under [~~Chapter 5, 7, 8, 9, 10, 11, 13, or 14, and~~];

1433 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

1434 (B) Chapter 7, Nonprofit Health Service Insurance Corporations;

1435 (C) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

1436 (D) Chapter 9, Insurance Fraternal;

1437 (E) Chapter 10, Annuities;

1438 (F) Chapter 11, Motor Clubs;

1439 (G) Chapter 13, Employee Welfare Funds and Plans;

1440 (H) Chapter 14, Foreign Insurers;

1441 (I) Chapter 37, Captive Insurance Companies Act; or

1442 (J) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and

1443 (ii) within the limits of its certificate of authority;

1444 (b) a joint underwriting group under Section [31A-2-214](#) or [31A-20-102](#);

1445 (c) an insurer doing business under Section [31A-15-103](#);

1446 (d) a person who submits to the commissioner a certificate from the United States
1447 Department of Labor, or such other evidence as satisfies the commissioner, that the laws of
1448 Utah are preempted with respect to specified activities of that person by Section 514 of the
1449 Employee Retirement Income Security Act of 1974 or other federal law; or

1450 (e) a person exempt from this title under Section [31A-1-103](#) or another applicable
1451 statute.

1452 (2) As used in this section, "insurer" includes a bail bond surety company, as defined in
1453 Section 31A-35-102.

1454 Section 7. Section 31A-4-115 is amended to read:

1455 **31A-4-115. Plan of orderly withdrawal.**

1456 (1) (a) When an insurer intends to withdraw from writing a line of insurance in this
1457 state or to reduce its total annual premium volume by 75% or more, the insurer shall file with
1458 the commissioner a plan of orderly withdrawal.

1459 (b) For purposes of this section, a discontinuance of a health benefit plan pursuant to
1460 one of the following provisions is a withdrawal from a line of insurance:

1461 (i) Subsection 31A-30-107(3)(e); or

1462 (ii) Subsection 31A-30-107.1(3)(e).

1463 (2) An insurer's plan of orderly withdrawal shall:

1464 (a) indicate the date the insurer intends to begin and complete its withdrawal plan; and

1465 (b) include provisions for:

1466 (i) meeting the insurer's contractual obligations;

1467 (ii) providing services to its Utah policyholders and claimants;

1468 (iii) meeting [any] applicable statutory obligations; and

1469 (iv) [(A)] the payment of a withdrawal fee of \$50,000 to the [Utah Comprehensive
1470 Health Insurance Pool if: (I) the insurer is an accident and health insurer; and (II) the insurer's
1471 line of business is not assumed or placed with another insurer approved by the commissioner;
1472 or (B) the payment of a withdrawal fee of \$50,000 to the department if: (I) the insurer is not
1473 an accident and health insurer; and (II)] department if the insurer's line of business is not
1474 assumed or placed with another insurer approved by the commissioner.

1475 (3) The commissioner shall approve a plan of orderly withdrawal if the plan of orderly
1476 withdrawal adequately demonstrates that the insurer will:

1477 (a) protect the interests of the people of the state;

1478 (b) meet the insurer's contractual obligations;

1479 (c) provide service to the insurer's Utah policyholders and claimants; and

1480 (d) meet [any] applicable statutory obligations.

1481 (4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for
1482 orderly withdrawal.

1483 (5) The commissioner may require an insurer to increase the deposit maintained in
 1484 accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in
 1485 the name of the commissioner upon finding, after an adjudicative proceeding that:

1486 (a) there is reasonable cause to conclude that the interests of the people of the state are
 1487 best served by such action; and

1488 (b) the insurer:

1489 (i) has filed a plan of orderly withdrawal; or

1490 (ii) intends to:

1491 (A) withdraw from writing a line of insurance in this state; or

1492 (B) reduce the insurer's total annual premium volume by 75% or more.

1493 (6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:

1494 (a) withdraws from writing insurance in this state without receiving the commissioner's
 1495 approval of a plan of orderly withdrawal; or

1496 (b) reduces its total annual premium volume by 75% or more in any year without
 1497 [~~having submitted a plan or receiving the commissioner's approval~~] receiving the
 1498 commissioner's approval of a plan of orderly withdrawal.

1499 (7) An insurer that withdraws from writing all lines of insurance in this state may not
 1500 resume writing insurance in this state for five years unless[~~-(a)~~] the commissioner finds that
 1501 the prohibition should be waived because the waiver is:

1502 [(i)] (a) in the public interest to promote competition; or

1503 [(ii)] (b) to resolve inequity in the marketplace[~~;-and~~].

1504 [~~(b) the insurer complies with Subsection 31A-30-108(5), if applicable.~~]

1505 (8) The commissioner shall adopt rules necessary to implement this section.

1506 Section 8. Section 31A-8-402.3 is amended to read:

1507 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**
 1508 **plans.**

1509 (1) Except as otherwise provided in this section, a group health benefit plan for a plan
 1510 sponsor is renewable and continues in force:

1511 (a) with respect to all eligible employees and dependents; and

1512 (b) at the option of the plan sponsor.

1513 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

1514 (a) for a network plan, if~~[(i)]~~ there is no longer any enrollee under the group health
1515 plan who lives, resides, or works in:

1516 ~~[(A)]~~ (i) the service area of the insurer; or

1517 ~~[(B)]~~ (ii) the area for which the insurer is authorized to do business; ~~[and] or~~

1518 ~~[(ii) in the case of the small employer market, the insurer applies the same criteria the~~
1519 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or]~~

1520 (b) for coverage made available in the small or large employer market only through an
1521 association, if:

1522 (i) the employer's membership in the association ceases; and

1523 (ii) the coverage is terminated uniformly without regard to any health status-related
1524 factor relating to any covered individual.

1525 (3) A health benefit plan for a plan sponsor may be discontinued if:

1526 (a) a condition described in Subsection (2) exists;

1527 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
1528 terms of the contract;

1529 (c) the plan sponsor:

1530 (i) performs an act or practice that constitutes fraud; or

1531 (ii) makes an intentional misrepresentation of material fact under the terms of the
1532 coverage;

1533 (d) the insurer:

1534 (i) elects to discontinue offering a particular health benefit product delivered or issued
1535 for delivery in this state; and

1536 (ii) (A) provides notice of the discontinuation in writing:

1537 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

1538 (II) at least 90 days before the date the coverage will be discontinued;

1539 (B) provides notice of the discontinuation in writing:

1540 (I) to the commissioner; and

1541 (II) at least three working days prior to the date the notice is sent to the affected plan
1542 sponsors, employees, and dependents of the plan sponsors or employees;

1543 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:

1544 (I) all other health benefit products currently being offered by the insurer in the market;

1545 or

1546 (II) in the case of a large employer, any other health benefit product currently being
1547 offered in that market; and

1548 (D) in exercising the option to discontinue that product and in offering the option of
1549 coverage in this section, acts uniformly without regard to:

1550 (I) the claims experience of a plan sponsor;

1551 (II) any health status-related factor relating to any covered participant or beneficiary; or

1552 (III) any health status-related factor relating to any new participant or beneficiary who

1553 may become eligible for the coverage; or

1554 (e) the insurer:

1555 (i) elects to discontinue all of the insurer's health benefit plans in:

1556 (A) the small employer market;

1557 (B) the large employer market; or

1558 (C) both the small employer and large employer markets; and

1559 (ii) (A) provides notice of the discontinuation in writing:

1560 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

1561 (II) at least 180 days before the date the coverage will be discontinued;

1562 (B) provides notice of the discontinuation in writing:

1563 (I) to the commissioner in each state in which an affected insured individual is known
1564 to reside; and

1565 (II) at least 30 working days prior to the date the notice is sent to the affected plan
1566 sponsors, employees, and the dependents of the plan sponsors or employees;

1567 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
1568 market; and

1569 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).

1570 (4) A large employer health benefit plan may be discontinued or nonrenewed:

1571 (a) if a condition described in Subsection (2) exists; or

1572 (b) for noncompliance with the insurer's:

1573 (i) minimum participation requirements; or

1574 (ii) employer contribution requirements.

1575 (5) A small employer health benefit plan may be discontinued or nonrenewed:

- 1576 (a) if a condition described in Subsection (2) exists; or
1577 (b) for noncompliance with the insurer's employer contribution requirements.
1578 (6) A small employer health benefit plan may be nonrenewed:
1579 (a) if a condition described in Subsection (2) exists; or
1580 (b) for noncompliance with the insurer's minimum participation requirements.
1581 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
1582 discontinued if after issuance of coverage the eligible employee:
1583 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
1584 or
1585 (ii) makes an intentional misrepresentation of material fact in connection with the
1586 coverage.
1587 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
1588 (i) 12 months after the date of discontinuance; and
1589 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
1590 to reenroll.
1591 (c) At the time the eligible employee's coverage is discontinued under Subsection
1592 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
1593 discontinued.
1594 (d) An eligible employee may not be discontinued under this Subsection (7) because of
1595 a fraud or misrepresentation that relates to health status.
1596 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to
1597 the employer:
1598 (a) with respect to coverage provided to an employer member of the association; and
1599 (b) if the health benefit plan is made available by an insurer in the employer market
1600 only through:
1601 (i) an association;
1602 (ii) a trust; or
1603 (iii) a discretionary group.
1604 (9) An insurer may modify a health benefit plan for a plan sponsor only:
1605 (a) at the time of coverage renewal; and
1606 (b) if the modification is effective uniformly among all plans with that product.

1607 Section 9. Section **31A-16-103** is amended to read:

1608 **31A-16-103. Acquisition of control of or merger with domestic insurer.**

1609 (1) (a) A person may not take the actions described in Subsections (1)(b) or (c) unless,
1610 at the time any offer, request, or invitation is made or any such agreement is entered into, or
1611 prior to the acquisition of securities if no offer or agreement is involved:

1612 (i) the person files with the commissioner a statement containing the information
1613 required by this section;

1614 (ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the
1615 insurer; and

1616 (iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.

1617 (b) Unless the person complies with Subsection (1)(a), a person other than the issuer
1618 may not make a tender offer for, a request or invitation for tenders of, or enter into any
1619 agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise,
1620 any voting security of a domestic insurer if after the acquisition, the person would directly,
1621 indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.

1622 (c) Unless the person complies with Subsection (1)(a), a person may not enter into an
1623 agreement to merge with or otherwise to acquire control of:

1624 (i) a domestic insurer; or

1625 (ii) any person controlling a domestic insurer.

1626 (d) (i) For purposes of this section, a domestic insurer includes any person controlling a
1627 domestic insurer unless the person as determined by the commissioner is either directly or
1628 through its affiliates primarily engaged in business other than the business of insurance.

1629 (ii) The controlling person described in Subsection (1)(d)(i) shall file with the
1630 commissioner a preacquisition notification containing the information required in Subsection
1631 (2) 30 calendar days before the proposed effective date of the acquisition.

1632 (iii) For the purposes of this section, "person" does not include any securities broker
1633 that in the usual and customary brokers function holds less than 20% of:

1634 (A) the voting securities of an insurance company; or

1635 (B) any person that controls an insurance company.

1636 (iv) This section applies to all domestic insurers and other entities licensed under
1637 Chapters 5, 7, 8, 9, and 11.

1638 (e) (i) An agreement for acquisition of control or merger as contemplated by this
1639 Subsection (1) is not valid or enforceable unless the agreement:

1640 (A) is in writing; and

1641 (B) includes a provision that the agreement is subject to the approval of the
1642 commissioner upon the filing of any applicable statement required under this chapter.

1643 (ii) A written agreement for acquisition or control that includes the provision described
1644 in Subsection (1)(e)(i) satisfies the requirements of this Subsection (1).

1645 (2) The statement to be filed with the commissioner under Subsection (1) shall be
1646 made under oath or affirmation and shall contain the following information:

1647 (a) the name and address of the "acquiring party," which means each person by whom
1648 or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to
1649 be effected; and

1650 (i) if the person is an individual:

1651 (A) the person's principal occupation;

1652 (B) a listing of all offices and positions held by the person during the past five years;

1653 and

1654 (C) any conviction of crimes other than minor traffic violations during the past 10
1655 years; and

1656 (ii) if the person is not an individual:

1657 (A) a report of the nature of its business operations during:

1658 (I) the past five years; or

1659 (II) for any lesser period as the person and any of its predecessors has been in
1660 existence;

1661 (B) an informative description of the business intended to be done by the person and
1662 the person's subsidiaries;

1663 (C) a list of all individuals who are or who have been selected to become directors or
1664 executive officers of the person, or individuals who perform, or who will perform functions
1665 appropriate to such positions; and

1666 (D) for each individual described in Subsection (2)(a)(ii)(C), the information required
1667 by Subsection (2)(a)(i) for each individual;

1668 (b) (i) the source, nature, and amount of the consideration used or to be used in

- 1669 effecting the merger or acquisition of control;
- 1670 (ii) a description of any transaction in which funds were or are to be obtained for the
- 1671 purpose of effecting the merger or acquisition of control, including any pledge of:
- 1672 (A) the insurer's stock; or
- 1673 (B) the stock of any of the insurer's subsidiaries or controlling affiliates; and
- 1674 (iii) the identity of persons furnishing the consideration;
- 1675 (c) (i) fully audited financial information, or other financial information considered
- 1676 acceptable by the commissioner, of the earnings and financial condition of each acquiring party
- 1677 for:
- 1678 (A) the preceding five fiscal years of each acquiring party; or
- 1679 (B) any lesser period the acquiring party and any of its predecessors shall have been in
- 1680 existence; and
- 1681 (ii) unaudited information:
- 1682 (A) similar to the information described in Subsection (2)(c)(i); and
- 1683 (B) prepared within the 90 days prior to the filing of the statement;
- 1684 (d) any plans or proposals which each acquiring party may have to:
- 1685 (i) liquidate the insurer;
- 1686 (ii) sell its assets;
- 1687 (iii) merge or consolidate the insurer with any person; or
- 1688 (iv) make any other material change in the insurer's:
- 1689 (A) business;
- 1690 (B) corporate structure; or
- 1691 (C) management;
- 1692 (e) (i) the number of shares of any security referred to in Subsection (1) that each
- 1693 acquiring party proposes to acquire;
- 1694 (ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in
- 1695 Subsection (1); and
- 1696 (iii) a statement as to the method by which the fairness of the proposal was arrived at;
- 1697 (f) the amount of each class of any security referred to in Subsection (1) that:
- 1698 (i) is beneficially owned; or
- 1699 (ii) concerning which there is a right to acquire beneficial ownership by each acquiring

1700 party;

1701 (g) a full description of any contract, arrangement, or understanding with respect to any

1702 security referred to in Subsection (1) in which any acquiring party is involved, including:

1703 (i) the transfer of any of the securities;

1704 (ii) joint ventures;

1705 (iii) loan or option arrangements;

1706 (iv) puts or calls;

1707 (v) guarantees of loans;

1708 (vi) guarantees against loss or guarantees of profits;

1709 (vii) division of losses or profits; or

1710 (viii) the giving or withholding of proxies;

1711 (h) a description of the purchase by any acquiring party of any security referred to in

1712 Subsection (1) during the 12 calendar months preceding the filing of the statement including:

1713 (i) the dates of purchase;

1714 (ii) the names of the purchasers; and

1715 (iii) the consideration paid or agreed to be paid for the purchase;

1716 (i) a description of:

1717 (i) any recommendations to purchase by any acquiring party any security referred to in

1718 Subsection (1) made during the 12 calendar months preceding the filing of the statement; or

1719 (ii) any recommendations made by anyone based upon interviews or at the suggestion

1720 of the acquiring party;

1721 (j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange

1722 offers for, and agreements to acquire or exchange any securities referred to in Subsection (1);

1723 and

1724 (ii) if distributed, copies of additional soliciting material relating to the transactions

1725 described in Subsection (2)(j)(i);

1726 (k) (i) the term of any agreement, contract, or understanding made with, or proposed to

1727 be made with, any broker-dealer as to solicitation of securities referred to in Subsection (1) for

1728 tender; and

1729 (ii) the amount of any fees, commissions, or other compensation to be paid to

1730 broker-dealers with regard to any agreement, contract, or understanding described in

- 1731 Subsection (2)(k)(i); and
- 1732 (l) any additional information the commissioner requires by rule, which the
1733 commissioner determines to be:
- 1734 (i) necessary or appropriate for the protection of policyholders of the insurer; or
1735 (ii) in the public interest.
- 1736 (3) The department may request:
- 1737 (a) (i) criminal background information maintained pursuant to Title 53, Chapter 10,
1738 Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
1739 (ii) complete Federal Bureau of Investigation criminal background checks through the
1740 national criminal history system.
- 1741 (b) Information obtained by the department from the review of criminal history records
1742 received under Subsection (3)(a) shall be used by the department for the purpose of:
- 1743 (i) verifying the information in Subsection (2)(a)(i);
1744 (ii) determining the integrity of persons who would control the operation of an insurer;
1745 and
- 1746 (iii) preventing persons who violate 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~] from
1747 engaging in the business of insurance in the state.
- 1748 (c) If the department requests the criminal background information, the department
1749 shall:
- 1750 (i) pay to the Department of Public Safety the costs incurred by the Department of
1751 Public Safety in providing the department criminal background information under Subsection
1752 (3)(a)(i);
- 1753 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
1754 of Investigation in providing the department criminal background information under
1755 Subsection (3)(a)(ii); and
- 1756 (iii) charge the person required to file the statement referred to in Subsection (1) a fee
1757 equal to the aggregate of Subsections (3)(c)(i) and (ii).
- 1758 (4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in
1759 the lender's ordinary course of business, the identity of the lender shall remain confidential, if
1760 the person filing the statement so requests.
- 1761 (b) (i) Under Subsection (2)(e), the commissioner may require a statement of the

1762 adjusted book value assigned by the acquiring party to each security in arriving at the terms of
1763 the offer.

1764 (ii) For purposes of this Subsection (4)(b), "adjusted book value" means each security's
1765 proportional interest in the capital and surplus of the insurer with adjustments that reflect:

1766 (A) market conditions;

1767 (B) business in force; and

1768 (C) other intangible assets or liabilities of the insurer.

1769 (c) The description required by Subsection (2)(g) shall identify the persons with whom
1770 the contracts, arrangements, or understandings have been entered into.

1771 (5) (a) If the person required to file the statement referred to in Subsection (1) is a
1772 partnership, limited partnership, syndicate, or other group, the commissioner may require that
1773 all the information called for by Subsections (2), (3), or (4) shall be given with respect to each:

1774 (i) partner of the partnership or limited partnership;

1775 (ii) member of the syndicate or group; and

1776 (iii) person who controls the partner or member.

1777 (b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation,
1778 or if the person required to file the statement referred to in Subsection (1) is a corporation, the
1779 commissioner may require that the information called for by Subsection (2) shall be given with
1780 respect to:

1781 (i) the corporation;

1782 (ii) each officer and director of the corporation; and

1783 (iii) each person who is directly or indirectly the beneficial owner of more than 10% of
1784 the outstanding voting securities of the corporation.

1785 (6) If any material change occurs in the facts set forth in the statement filed with the
1786 commissioner and sent to the insurer pursuant to Subsection (2), an amendment setting forth
1787 the change, together with copies of all documents and other material relevant to the change,
1788 shall be filed with the commissioner and sent to the insurer within two business days after the
1789 filing person learns of such change.

1790 (7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection
1791 (1) is proposed to be made by means of a registration statement under the Securities Act of
1792 1933, or under circumstances requiring the disclosure of similar information under the

1793 Securities Exchange Act of 1934, or under a state law requiring similar registration or
1794 disclosure, a person required to file the statement referred to in Subsection (1) may use copies
1795 of any registration or disclosure documents in furnishing the information called for by the
1796 statement.

1797 (8) (a) The commissioner shall approve any merger or other acquisition of control
1798 referred to in Subsection (1) unless, after a public hearing on the merger or acquisition, the
1799 commissioner finds that:

1800 (i) after the change of control, the domestic insurer referred to in Subsection (1) would
1801 not be able to satisfy the requirements for the issuance of a license to write the line or lines of
1802 insurance for which it is presently licensed;

1803 (ii) the effect of the merger or other acquisition of control would:

1804 (A) substantially lessen competition in insurance in this state; or

1805 (B) tend to create a monopoly in insurance;

1806 (iii) the financial condition of any acquiring party might:

1807 (A) jeopardize the financial stability of the insurer; or

1808 (B) prejudice the interest of:

1809 (I) its policyholders; or

1810 (II) any remaining securityholders who are unaffiliated with the acquiring party;

1811 (iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in
1812 Subsection (1) are unfair and unreasonable to the securityholders of the insurer;

1813 (v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its
1814 assets, or consolidate or merge it with any person, or to make any other material change in its
1815 business or corporate structure or management, are:

1816 (A) unfair and unreasonable to policyholders of the insurer; and

1817 (B) not in the public interest; or

1818 (vi) the competence, experience, and integrity of those persons who would control the
1819 operation of the insurer are such that it would not be in the interest of the policyholders of the
1820 insurer and the public to permit the merger or other acquisition of control.

1821 (b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not
1822 be considered unfair if the adjusted book values under Subsection (2)(e):

1823 (i) are disclosed to the securityholders; and

1824 (ii) determined by the commissioner to be reasonable.

1825 (9) (a) The public hearing referred to in Subsection (8) shall be held within 30 days
1826 after the statement required by Subsection (1) is filed.

1827 (b) (i) At least 20 days notice of the hearing shall be given by the commissioner to the
1828 person filing the statement.

1829 (ii) Affected parties may waive the notice required by this Subsection (9)(b).

1830 (iii) Not less than seven days notice of the public hearing shall be given by the person
1831 filing the statement to:

1832 (A) the insurer; and
1833 (B) any person designated by the commissioner.

1834 (c) The commissioner shall make a determination within 30 days after the conclusion
1835 of the hearing.

1836 (d) At the hearing, the person filing the statement, the insurer, any person to whom
1837 notice of hearing was sent, and any other person whose interest may be affected by the hearing
1838 may:

1839 (i) present evidence;
1840 (ii) examine and cross-examine witnesses; and
1841 (iii) offer oral and written arguments.

1842 (e) (i) A person or insurer described in Subsection (9)(d) may conduct discovery
1843 proceedings in the same manner as is presently allowed in the district courts of this state.

1844 (ii) All discovery proceedings shall be concluded not later than three days before the
1845 commencement of the public hearing.

1846 (10) (a) The commissioner may retain technical experts to assist in reviewing all, or a
1847 portion of, information filed in connection with a proposed merger or other acquisition of
1848 control referred to in Subsection (1).

1849 (b) In determining whether any of the conditions in Subsection (8) exist, the
1850 commissioner may consider the findings of technical experts employed to review applicable
1851 filings.

1852 (c) (i) A technical expert employed under Subsection (10)(a) shall present to the
1853 commissioner a statement of all expenses incurred by the technical expert in conjunction with
1854 the technical expert's review of a proposed merger or other acquisition of control.

1855 (ii) At the commissioner's direction the acquiring person shall compensate the technical
1856 expert at customary rates for time and expenses:

1857 (A) necessarily incurred; and

1858 (B) approved by the commissioner.

1859 (iii) The acquiring person shall:

1860 (A) certify the consolidated account of all charges and expenses incurred for the review
1861 by technical experts;

1862 (B) retain a copy of the consolidated account described in Subsection (10)(c)(iii)(A);

1863 and

1864 (C) file with the department as a public record a copy of the consolidated account
1865 described in Subsection (10)(c)(iii)(A).

1866 (11) (a) (i) If a domestic insurer proposes to merge into another insurer, any
1867 securityholder electing to exercise a right of dissent may file with the insurer a written request
1868 for payment of the adjusted book value given in the statement required by Subsection (1) and
1869 approved under Subsection (8), in return for the surrender of the security holder's securities.

1870 (ii) The request described in Subsection (11)(a)(i) shall be filed not later than 10 days
1871 after the day of the securityholders' meeting where the corporate action is approved.

1872 (b) The dissenting securityholder is entitled to and the insurer is required to pay to the
1873 dissenting securityholder the specified value within 60 days of receipt of the dissenting security
1874 holder's security.

1875 (c) Persons electing under this Subsection (11) to receive cash for their securities waive
1876 the dissenting shareholder and appraisal rights otherwise applicable under Title 16, Chapter
1877 10a, Part 13, Dissenters' Rights.

1878 (d) (i) This Subsection (11) provides an elective procedure for dissenting
1879 securityholders to resolve their objections to the plan of merger.

1880 (ii) This section does not restrict the rights of dissenting securityholders under Title 16,
1881 Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this
1882 Subsection (11).

1883 (12) (a) All statements, amendments, or other material filed under Subsection (1), and
1884 all notices of public hearings held under Subsection (8), shall be mailed by the insurer to its
1885 securityholders within five business days after the insurer has received the statements,

1886 amendments, other material, or notices.

1887 (b) (i) Mailing expenses shall be paid by the person making the filing.

1888 (ii) As security for the payment of mailing expenses, that person shall file with the
1889 commissioner an acceptable bond or other deposit in an amount determined by the
1890 commissioner.

1891 (13) This section does not apply to any offer, request, invitation, agreement, or
1892 acquisition that the commissioner by order exempts from the requirements of this section as:

1893 (a) not having been made or entered into for the purpose of, and not having the effect
1894 of, changing or influencing the control of a domestic insurer; or

1895 (b) as otherwise not comprehended within the purposes of this section.

1896 (14) The following are violations of this section:

1897 (a) the failure to file any statement, amendment, or other material required to be filed
1898 pursuant to Subsections (1), (2), and (5); or

1899 (b) the effectuation, or any attempt to effectuate, an acquisition of control of or merger
1900 with a domestic insurer unless the commissioner has given the commissioner's approval to the
1901 acquisition or merger.

1902 (15) (a) The courts of this state are vested with jurisdiction over:

1903 (i) a person who:

1904 (A) files a statement with the commissioner under this section; and

1905 (B) is not resident, domiciled, or authorized to do business in this state; and

1906 (ii) overall actions involving persons described in Subsection (15)(a)(i) arising out of a
1907 violation of this section.

1908 (b) A person described in Subsection (15)(a) is considered to have performed acts
1909 equivalent to and constituting an appointment of the commissioner by that person, to be that
1910 person's lawful agent upon whom may be served all lawful process in any action, suit, or
1911 proceeding arising out of a violation of this section.

1912 (c) A copy of a lawful process described in Subsection (15)(b) shall be:

1913 (i) served on the commissioner; and

1914 (ii) transmitted by registered or certified mail by the commissioner to the person at that
1915 person's last-known address.

1916 Section 10. Section ~~31A-17-607~~ is amended to read:

1917 **31A-17-607. Hearings.**

1918 (1) (a) Following receipt of a notice described in Subsection (2), the insurer or health
1919 organization shall have the right to a confidential departmental hearing at which the insurer or
1920 health organization may challenge ~~any~~ a determination or action by the commissioner.

1921 (b) The insurer or health organization shall notify the commissioner of its request for a
1922 hearing within five days after the notification by the commissioner under ~~[Subsections~~
1923 ~~31A-17-604(1), (2), and (3)]~~ Subsection (2).

1924 (c) Upon receipt of the insurer's or health organization's request for a hearing, the
1925 commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than
1926 30 days after the date of the insurer's or health organization's request.

1927 (2) An insurer or health organization has the right to a hearing under Subsection (1)
1928 after:

1929 (a) notification to an insurer or health organization by the commissioner of an adjusted
1930 RBC report;

1931 (b) notification to an insurer or health organization by the commissioner that:

1932 (i) the insurer's or health organization's RBC plan or revised RBC plan is
1933 unsatisfactory; and

1934 (ii) the notification constitutes a regulatory action level event with respect to the
1935 insurer or health organization;

1936 (c) notification to any insurer or health organization by the commissioner that the
1937 insurer or health organization has failed to adhere to its RBC plan or revised RBC plan and that
1938 the failure has substantial adverse effect on the ability of the insurer or health organization to
1939 eliminate the company action level event with respect to the insurer or health organization in
1940 accordance with its RBC plan or revised RBC plan; or

1941 (d) notification to an insurer or health organization by the commissioner of a corrective
1942 order with respect to the insurer or health organization.

1943 Section 11. Section ~~31A-22-428~~ is amended to read:

1944 **31A-22-428. Interest payable on life insurance proceeds.**

1945 (1) For a life insurance policy delivered or issued for delivery in this state on or after
1946 May 5, 2008, the insurer shall pay interest on the death proceeds payable upon the death of the
1947 insured.

1948 (2) (a) Except as provided in Subsection (4), for the period beginning on the date of
1949 death and ending the day before the day described in Subsection (3)(b), interest under
1950 Subsection (1) shall accrue at a rate no less than the greater of:

1951 (i) the rate applicable to policy funds left on deposit; ~~[or]~~ and
1952 (ii) ~~[if there is no rate described in Subsection (2)(a)(i), at]~~ the Two Year Treasury
1953 Constant Maturity Rate as published by the Federal Reserve.

1954 (b) If there is no rate applicable to policy funds on deposit as stated in Subsection
1955 (2)(a)(i), then the Two Year Treasury Constant Maturity Rates as published by the Federal
1956 Reserve applies.

1957 ~~[(b)]~~ (c) The rate described in Subsection (2)(a) or (b) is the rate in effect on the day on
1958 which the death occurs.

1959 ~~[(c)]~~ (d) Interest is payable until the day on which the claim is paid.

1960 (3) (a) Unless the claim is paid and except as provided in Subsection (4), beginning on
1961 the day described in Subsection (3)(b) and ending the day on which the claim is paid, interest
1962 shall accrue at the rate in Subsection (2) plus additional interest at the rate of 10% annually.

1963 (b) Interest accrues under Subsection (3)(a) beginning with the day that is 31 days from
1964 the latest of:

1965 (i) the day on which the insurer receives proof of death;

1966 (ii) the day on which the insurer receives sufficient information to determine:

1967 (A) liability;

1968 (B) the extent of the liability; and

1969 (C) the appropriate payee legally entitled to the proceeds; and

1970 (iii) the day on which:

1971 (A) legal impediments to payment of proceeds that depend on the action of parties
1972 other than the insurer are resolved; and

1973 (B) the insurer receives sufficient evidence of the resolution of the legal impediments
1974 described in Subsection (3)(b)(iii)(A).

1975 (4) A court of competent jurisdiction may require payment of interest from the date of
1976 death to the day on which a claim is paid at a rate equal to the sum of:

1977 (a) the rate specified in Subsection (2); and

1978 (b) the legal rate identified in Subsection 15-1-1(2).

1979 Section 12. Section 31A-22-617 is amended to read:

1980 **31A-22-617. Preferred provider contract provisions.**

1981 Health insurance policies may provide for insureds to receive services or
1982 reimbursement under the policies in accordance with preferred health care provider contracts as
1983 follows:

1984 (1) Subject to restrictions under this section, [~~any~~] an insurer or third party
1985 administrator may enter into contracts with health care providers as defined in Section
1986 78B-3-403 under which the health care providers agree to supply services, at prices specified in
1987 the contracts, to persons insured by an insurer.

1988 (a) (i) A health care provider contract may require the health care provider to accept the
1989 specified payment in this Subsection (1) as payment in full, relinquishing the right to collect
1990 additional amounts from the insured person.

1991 (ii) In [~~any~~] a dispute involving a provider's claim for reimbursement, the same shall be
1992 determined in accordance with applicable law, the provider contract, the subscriber contract,
1993 and the insurer's written payment policies in effect at the time services were rendered.

1994 (iii) If the parties are unable to resolve their dispute, the matter shall be subject to
1995 binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except
1996 the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii)
1997 does not apply to the claim of a general acute hospital to the extent it is inconsistent with the
1998 hospital's provider agreement.

1999 (iv) An organization may not penalize a provider solely for pursuing a claims dispute
2000 or otherwise demanding payment for a sum believed owing.

2001 (v) If an insurer permits another entity with which it does not share common ownership
2002 or control to use or otherwise lease one or more of the organization's networks of participating
2003 providers, the organization shall ensure, at a minimum, that the entity pays participating
2004 providers in accordance with the same fee schedule and general payment policies as the
2005 organization would for that network.

2006 (b) The insurance contract may reward the insured for selection of preferred health care
2007 providers by:

2008 (i) reducing premium rates;

2009 (ii) reducing deductibles;

2010 (iii) coinsurance;

2011 (iv) other copayments; or

2012 (v) any other reasonable manner.

2013 (c) If the insurer is a managed care organization, as defined in Subsection

2014 31A-27a-403(1)(f):

2015 (i) the insurance contract and the health care provider contract shall provide that in the

2016 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

2017 (A) require the health care provider to continue to provide health care services under

2018 the contract until the earlier of:

2019 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for

2020 liquidation; or

2021 (II) the date the term of the contract ends; and

2022 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to

2023 receive from the managed care organization during the time period described in Subsection

2024 (1)(c)(i)(A);

2025 (ii) the provider is required to:

2026 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

2027 (B) relinquish the right to collect additional amounts from the insolvent managed care

2028 organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);

2029 (iii) if the contract between the health care provider and the managed care organization

2030 has not been reduced to writing, or the contract fails to contain the ~~[language required by]~~

2031 requirements described in Subsection (1)(c)(i), the provider may not collect or attempt to

2032 collect from the enrollee:

2033 (A) sums owed by the insolvent managed care organization; or

2034 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

2035 (iv) the following may not bill or maintain ~~[any]~~ an action at law against an enrollee to

2036 collect sums owed by the insolvent managed care organization or the amount of the regular fee

2037 reduction authorized under Subsection (1)(c)(i)(B):

2038 (A) a provider;

2039 (B) an agent;

2040 (C) a trustee; or

2041 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
2042 (v) notwithstanding Subsection (1)(c)(i):

2043 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's
2044 regular fee set forth in the contract; and

2045 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments
2046 for services received from the provider that the enrollee was required to pay before the filing
2047 of:

2048 (I) a petition for rehabilitation; or

2049 (II) a petition for liquidation.

2050 (2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health
2051 care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on
2052 or after January 1, 2014.

2053 (b) When reimbursing for services of health care providers not under contract, the
2054 insurer may make direct payment to the insured.

2055 (c) An insurer using preferred health care provider contracts may impose a deductible
2056 on coverage of health care providers not under contract.

2057 (d) When selecting health care providers with whom to contract under Subsection (1),
2058 an insurer may not unfairly discriminate between classes of health care providers, but may
2059 discriminate within a class of health care providers, subject to Subsection (7).

2060 (e) For purposes of this section, unfair discrimination between classes of health care
2061 providers includes:

2062 (i) refusal to contract with class members in reasonable proportion to the number of
2063 insureds covered by the insurer and the expected demand for services from class members; and

2064 (ii) refusal to cover procedures for one class of providers that are:

2065 (A) commonly used by members of the class of health care providers for the treatment
2066 of illnesses, injuries, or conditions;

2067 (B) otherwise covered by the insurer; and

2068 (C) within the scope of practice of the class of health care providers.

2069 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
2070 to the insured that it has entered into preferred health care provider contracts. The insurer shall
2071 provide sufficient detail on the preferred health care provider contracts to permit the insured to

2072 agree to the terms of the insurance contract. The insurer shall provide at least the following
2073 information:

2074 (a) a list of the health care providers under contract, and if requested their business
2075 locations and specialties;

2076 (b) a description of the insured benefits, including [~~any~~] deductibles, coinsurance, or
2077 other copayments;

2078 (c) a description of the quality assurance program required under Subsection (4); and

2079 (d) a description of the adverse benefit determination procedures required under
2080 Subsection (5).

2081 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
2082 assurance program for assuring that the care provided by the health care providers under
2083 contract meets prevailing standards in the state.

2084 (b) The commissioner in consultation with the executive director of the Department of
2085 Health may designate qualified persons to perform an audit of the quality assurance program.
2086 The auditors shall have full access to all records of the organization and its health care
2087 providers, including medical records of individual patients.

2088 (c) The information contained in the medical records of individual patients shall
2089 remain confidential. All information, interviews, reports, statements, memoranda, or other data
2090 furnished for purposes of the audit and any findings or conclusions of the auditors are
2091 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
2092 proceeding except hearings before the commissioner concerning alleged violations of this
2093 section.

2094 (5) An insurer using preferred health care provider contracts shall provide a reasonable
2095 procedure for resolving complaints and adverse benefit determinations initiated by the insureds
2096 and health care providers.

2097 (6) An insurer may not contract with a health care provider for treatment of illness or
2098 injury unless the health care provider is licensed to perform that treatment.

2099 (7) (a) A health care provider or insurer may not discriminate against a preferred health
2100 care provider for agreeing to a contract under Subsection (1).

2101 (b) [~~Any~~] A health care provider licensed to treat [~~any~~] an illness or injury within the
2102 scope of the health care provider's practice, who is willing and able to meet the terms and

2103 conditions established by the insurer for designation as a preferred health care provider, shall
 2104 be able to apply for and receive the designation as a preferred health care provider. Contract
 2105 terms and conditions may include reasonable limitations on the number of designated preferred
 2106 health care providers based upon substantial objective and economic grounds, or expected use
 2107 of particular services based upon prior provider-patient profiles.

2108 (8) Upon the written request of a provider excluded from a provider contract, the
 2109 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
 2110 based on the criteria set forth in Subsection (7)(b).

2111 [~~(9)~~] Except as provided in Subsection ~~31A-22-618.5(3)(a)~~, insurers are subject to
 2112 Sections ~~31A-22-613.5, 31A-22-614.5, and 31A-22-618.~~]

2113 [~~(10)~~] (9) Nothing in this section is to be construed as to require an insurer to offer a
 2114 certain benefit or service as part of a health benefit plan.

2115 [~~(11)~~] (10) This section does not apply to catastrophic mental health coverage provided
 2116 in accordance with Section ~~31A-22-625.~~

2117 [~~(12)~~] (11) Notwithstanding [~~the provisions of~~] Subsection (1), Subsection (7)(b), and
 2118 Section ~~31A-22-618~~, an insurer or third party administrator is not required to, but may, enter
 2119 into [~~contracts~~] a contract with a licensed athletic [~~trainers~~] trainer, licensed under Title 58,
 2120 Chapter 40a, Athletic Trainer Licensing Act.

2121 Section 13. Section ~~31A-22-618.5~~ is amended to read:

2122 **31A-22-618.5. Health benefit plan offerings.**

2123 (1) The purpose of this section is to increase the range of health benefit plans available
 2124 in the small group, small employer group, large group, and individual insurance markets.

2125 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
 2126 Organizations and Limited Health Plans:

2127 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
 2128 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
 2129 and

2130 (b) may offer to a potential purchaser one or more health benefit plans that:

2131 (i) are not subject to one or more of the following:

2132 (A) the limitations on insured indemnity benefits in Subsection ~~31A-8-105(4)~~;

2133 (B) the limitation on point of service products in Subsections ~~31A-8-408(3)~~ through

2134 (6);

2135 (C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in
2136 Section 31A-8-101; or

2137 (D) coverage mandates enacted after January 1, 2009 that are not required by federal
2138 law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate
2139 enacted after January 1, 2009; and

2140 (ii) when offering a health plan under this section, provide coverage for an emergency
2141 medical condition as required by Section 31A-22-627 as follows:

2142 (A) within the organization's service area, covered services shall include health care
2143 services from nonaffiliated providers when medically necessary to stabilize an emergency
2144 medical condition; and

2145 (B) outside the organization's service area, covered services shall include medically
2146 necessary health care services for the treatment of an emergency medical condition that are
2147 immediately required while the enrollee is outside the geographic limits of the organization's
2148 service area.

2149 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
2150 Maintenance Organizations and Limited Health Plans:

2151 (a) [~~notwithstanding Subsection 31A-22-617(9);~~] may offer a health benefit plan that is
2152 not subject to Section 31A-22-618;

2153 (b) when offering a health plan under this Subsection (3), shall provide coverage of
2154 emergency care services as required by Section 31A-22-627; and

2155 (c) is not subject to coverage mandates enacted after January 1, 2009 that are not
2156 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
2157 after January 1, 2009.

2158 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under
2159 Subsection (2)(b).

2160 (5) (a) Any difference in price between a health benefit plan offered under Subsections
2161 (2)(a) and (b) shall be based on actuarially sound data.

2162 (b) Any difference in price between a health benefit plan offered under Subsection
2163 (3)(a) shall be based on actuarially sound data.

2164 (6) Nothing in this section limits the number of health benefit plans that an insurer may

2165 offer.

2166 Section 14. Section **31A-22-625** is amended to read:

2167 **31A-22-625. Catastrophic coverage of mental health conditions.**

2168 (1) As used in this section:

2169 (a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan
2170 that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or
2171 outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden
2172 on an insured for the evaluation and treatment of a mental health condition than for the
2173 evaluation and treatment of a physical health condition.

2174 (ii) "Catastrophic mental health coverage" may include a restriction on cost sharing
2175 factors, such as deductibles, copayments, or coinsurance, before reaching a maximum
2176 out-of-pocket limit.

2177 (iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket
2178 limit for physical health conditions and another maximum out-of-pocket limit for mental health
2179 conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit
2180 for mental health conditions may not exceed the out-of-pocket limit for physical health
2181 conditions.

2182 (b) (i) "50/50 mental health coverage" means coverage in a health benefit plan that
2183 pays for at least 50% of covered services for the diagnosis and treatment of mental health
2184 conditions.

2185 (ii) "50/50 mental health coverage" may include a restriction on:

2186 (A) episodic limits;

2187 (B) inpatient or outpatient service limits; or

2188 (C) maximum out-of-pocket limits.

2189 (c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

2190 (d) (i) "Mental health condition" means a condition or disorder involving mental illness
2191 that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as
2192 periodically revised.

2193 (ii) "Mental health condition" does not include the following when diagnosed as the
2194 primary or substantial reason or need for treatment:

2195 (A) a marital or family problem;

2196 (B) a social, occupational, religious, or other social maladjustment;
2197 (C) a conduct disorder;
2198 (D) a chronic adjustment disorder;
2199 (E) a psychosexual disorder;
2200 (F) a chronic organic brain syndrome;
2201 (G) a personality disorder;
2202 (H) a specific developmental disorder or learning disability; or
2203 (I) an intellectual disability.
2204 (e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.
2205 (2) (a) At the time of purchase and renewal on or before January 1, 2014, an insurer
2206 shall offer to a small employer that it insures or seeks to insure a choice between:
2207 (i) (A) catastrophic mental health coverage; or
2208 (B) federally qualified mental health coverage as described in Subsection (3); and
2209 (ii) 50/50 mental health coverage.
2210 (b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:
2211 (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels
2212 that exceed the minimum requirements of this section; or
2213 (ii) coverage that excludes benefits for mental health conditions.
2214 (c) A small employer may, at its option, regardless of the employer's previous coverage
2215 for mental health conditions, choose either:
2216 (i) coverage offered under Subsection (2)(a)(i);
2217 (ii) 50/50 mental health coverage; or
2218 (iii) coverage offered under Subsection (2)(b).
2219 (d) An insurer is exempt from the 30% index rating restriction in Section
2220 [31A-30-106.1](#) and, for the first year only that the employer chooses coverage that meets or
2221 exceeds catastrophic mental health coverage, the 15% annual adjustment restriction in Section
2222 [31A-30-106.1](#), for ~~any~~ a small employer with 20 or less enrolled employees who chooses
2223 coverage that meets or exceeds catastrophic mental health coverage.
2224 (3) (a) An insurer shall offer a large employer mental health and substance use disorder
2225 benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec.
2226 300gg-26, and federal regulations adopted pursuant to that act.

2227 (b) An insurer shall provide in an individual or small employer health benefit plan,
2228 mental health and substance use disorder benefits in compliance with Sections 2705 and 2711
2229 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted
2230 pursuant to that act.

2231 (4) (a) An insurer may provide catastrophic mental health coverage to a small employer
2232 through a managed care organization or system in a manner consistent with Chapter 8, Health
2233 Maintenance Organizations and Limited Health Plans, regardless of whether the insurance
2234 policy uses a managed care organization or system for the treatment of physical health
2235 conditions.

2236 (b) (i) Notwithstanding any other provision of this title, an insurer may:

2237 (A) establish a closed panel of providers for catastrophic mental health coverage; and

2238 (B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider
2239 unless:

2240 (I) the insured is referred to a nonpanel provider with the prior authorization of the
2241 insurer; and

2242 (II) the nonpanel provider agrees to follow the insurer's protocols and treatment
2243 guidelines.

2244 (ii) If an insured receives services from a nonpanel provider in the manner permitted by
2245 Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the
2246 average amount paid by the insurer for comparable services of panel providers under a
2247 noncapitated arrangement who are members of the same class of health care providers.

2248 (iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a
2249 referral to a nonpanel provider.

2250 (c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a
2251 mental health condition shall be rendered:

2252 (i) by a mental health therapist as defined in Section [58-60-102](#); or

2253 (ii) in a health care facility:

2254 (A) licensed or otherwise authorized to provide mental health services pursuant to:

2255 (I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

2256 (II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and

2257 (B) that provides a program for the treatment of a mental health condition pursuant to a

2258 written plan.

2259 (5) The commissioner may prohibit an insurance policy that provides mental health
2260 coverage in a manner that is inconsistent with this section.

2261 (6) The commissioner ~~[shall: (a)]~~ may adopt rules, in accordance with Title 63G,
2262 Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this
2263 section~~[-and].~~

2264 ~~[(b) provide general figures on the percentage of insurance policies that include:]~~

2265 ~~[(i) no mental health coverage;]~~

2266 ~~[(ii) 50/50 mental health coverage;]~~

2267 ~~[(iii) catastrophic mental health coverage; and]~~

2268 ~~[(iv) coverage that exceeds the minimum requirements of this section.]~~

2269 ~~[(7) This section may not be construed as discouraging or otherwise preventing an~~
2270 ~~insurer from providing mental health coverage in connection with an individual insurance~~
2271 ~~policy.]~~

2272 Section 15. Section 31A-22-635 is amended to read:

2273 **31A-22-635. Uniform application -- Uniform waiver of coverage -- Information**
2274 **on Health Insurance Exchange.**

2275 (1) For purposes of this section, "insurer":

2276 (a) is defined in Subsection 31A-22-634(1); and

2277 (b) includes the state employee's risk pool under Section 49-20-202.

2278 (2) (a) Insurers offering a health benefit plan to an individual or small employer shall
2279 use a uniform application form.

2280 (b) The uniform application form:

2281 (i) ~~[except for cancer and transplants,]~~ may not include questions about an applicant's
2282 health history ~~[prior to the previous five years];~~ and

2283 (ii) shall be shortened and simplified in accordance with rules adopted by the
2284 commissioner.

2285 (c) Insurers offering a health benefit plan to a small employer shall use a uniform
2286 waiver of coverage form, which may not include health status related questions ~~[other than~~
2287 ~~pregnancy]~~, and is limited to:

2288 (i) information that identifies the employee;

2289 (ii) proof of the employee's insurance coverage; and
2290 (iii) a statement that the employee declines coverage with a particular employer group.
2291 (3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and
2292 uniform waiver of coverage forms may, if the combination or modification is approved by the
2293 commissioner, be combined or modified to facilitate a more efficient and consumer friendly
2294 experience for:
2295 (a) enrollees using the Health Insurance Exchange; or
2296 (b) insurers using electronic applications.
2297 (4) The uniform application form, and uniform waiver form, shall be adopted and
2298 approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative
2299 Rulemaking Act.
2300 (5) (a) An insurer who offers a health benefit plan [~~in either the group or individual~~
2301 ~~market~~] on the Health Insurance Exchange created in Section 63M-1-2504, shall:
2302 (i) accept and process an electronic submission of the uniform application or uniform
2303 waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to
2304 Section 63M-1-2506;
2305 (ii) if requested, provide the applicant with a copy of the completed application either
2306 by mail or electronically;
2307 (iii) post all health benefit plans offered by the insurer in the defined contribution
2308 arrangement market on the Health Insurance Exchange; and
2309 (iv) post the information required by Subsection (6) on the Health Insurance Exchange
2310 for every health benefit plan the insurer offers on the Health Insurance Exchange.
2311 (b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans
2312 on the Health Insurance Exchange may not directly or indirectly offer products on the Health
2313 Insurance Exchange that are not health benefit plans.
2314 (c) Notwithstanding Subsection (5)(b):
2315 (i) an insurer may offer a health savings account on the Health Insurance Exchange;
2316 [~~and~~]
2317 (ii) an insurer may offer dental [~~and vision~~] plans on the Health Insurance Exchange
2318 [~~if~~]; and
2319 [~~(A) the department determines, after study and consultation with the Health System~~

2320 ~~Reform Task Force, that the department is able to establish standards for dental and vision~~
2321 ~~policies offered on the Health Insurance Exchange, and the department determines whether a~~
2322 ~~risk adjuster mechanism is necessary for a defined contribution vision and dental plan market~~
2323 ~~on the Health Insurance Exchange; and]~~

2324 [(B)] (iii) the department~~[, in accordance with recommendations from the Health~~
2325 ~~System Reform Task Force, adopts]~~ may make administrative rules to regulate the offer of
2326 dental ~~[and vision]~~ plans on the Health Insurance Exchange.

2327 (6) An insurer shall provide the commissioner and the Health Insurance Exchange with
2328 the following information for each health benefit plan submitted to the Health Insurance
2329 Exchange, in the electronic format required by Subsection 63M-1-2506(1):

2330 (a) plan design, benefits, and options offered by the health benefit plan including state
2331 mandates the plan does not cover;

2332 (b) information and Internet address to online provider networks;

2333 (c) wellness programs and incentives;

2334 (d) descriptions of prescription drug benefits, exclusions, or limitations;

2335 (e) the percentage of claims paid by the insurer within 30 days of the date a claim is
2336 submitted to the insurer for the prior year; and

2337 (f) the claims denial and insurer transparency information developed in accordance
2338 with Subsection 31A-22-613.5(4).

2339 (7) The department shall post on the Health Insurance Exchange the department's
2340 solvency rating for each insurer who posts a health benefit plan on the Health Insurance
2341 Exchange. The solvency rating for each insurer shall be based on methodology established by
2342 the department by administrative rule and shall be updated each calendar year.

2343 (8) (a) The commissioner may request information from an insurer under Section
2344 31A-22-613.5 to verify the data submitted to the department and to the Health Insurance
2345 Exchange.

2346 (b) The commissioner shall regulate ~~[any]~~ the fees charged by insurers to an enrollee
2347 for a uniform application form or electronic submission of the application forms.

2348 Section 16. Section 31A-22-721 is amended to read:

2349 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**
2350 **nonrenewal.**

- 2351 (1) Except as otherwise provided in this section, a health benefit plan for a plan
2352 sponsor is renewable and continues in force:
- 2353 (a) with respect to all eligible employees and dependents; and
2354 (b) at the option of the plan sponsor.
- 2355 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:
- 2356 (a) for a network plan, if~~[(t)]~~ there is no longer any enrollee under the group health
2357 plan who lives, resides, or works in:
- 2358 ~~[(A)]~~ (i) the service area of the insurer; or
2359 ~~[(B)]~~ (ii) the area for which the insurer is authorized to do business; ~~[and] or~~
2360 ~~[(ii) in the case of the small employer market, the insurer applies the same criteria the~~
2361 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or]~~
- 2362 (b) for coverage made available in the small or large employer market only through an
2363 association, if:
- 2364 (i) the employer's membership in the association ceases; and
2365 (ii) the coverage is terminated uniformly without regard to any health status-related
2366 factor relating to any covered individual.
- 2367 (3) A health benefit plan for a plan sponsor may be discontinued if:
- 2368 (a) a condition described in Subsection (2) exists;
2369 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
2370 terms of the contract;
- 2371 (c) the plan sponsor:
- 2372 (i) performs an act or practice that constitutes fraud; or
2373 (ii) makes an intentional misrepresentation of material fact under the terms of the
2374 coverage;
- 2375 (d) the insurer:
- 2376 (i) elects to discontinue offering a particular health benefit product delivered or issued
2377 for delivery in this state;
- 2378 (ii) (A) provides notice of the discontinuation in writing:
2379 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
2380 (II) at least 90 days before the date the coverage will be discontinued;
- 2381 (B) provides notice of the discontinuation in writing:

- 2382 (I) to the commissioner; and
- 2383 (II) at least three working days prior to the date the notice is sent to the affected plan
- 2384 sponsors, employees, and dependents of plan sponsors or employees;
- 2385 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
- 2386 other health benefit products currently being offered:
- 2387 (I) by the insurer in the market; or
- 2388 (II) in the case of a large employer, any other health benefit plan currently being
- 2389 offered in that market; and
- 2390 (D) in exercising the option to discontinue that product and in offering the option of
- 2391 coverage in this section, the insurer acts uniformly without regard to:
- 2392 (I) the claims experience of a plan sponsor;
- 2393 (II) any health status-related factor relating to any covered participant or beneficiary; or
- 2394 (III) any health status-related factor relating to a new participant or beneficiary who
- 2395 may become eligible for coverage; or
- 2396 (e) the insurer:
- 2397 (i) elects to discontinue all of the insurer's health benefit plans:
- 2398 (A) in the small employer market; or
- 2399 (B) the large employer market; or
- 2400 (C) both the small and large employer markets; and
- 2401 (ii) (A) provides notice of the discontinuance in writing:
- 2402 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
- 2403 (II) at least 180 days before the date the coverage will be discontinued;
- 2404 (B) provides notice of the discontinuation in writing:
- 2405 (I) to the commissioner in each state in which an affected insured individual is known
- 2406 to reside; and
- 2407 (II) at least 30 business days prior to the date the notice is sent to the affected plan
- 2408 sponsors, employees, and dependents of a plan sponsor or employee;
- 2409 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
- 2410 market; and
- 2411 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
- 2412 (4) A large employer health benefit plan may be discontinued or nonrenewed:

- 2413 (a) if a condition described in Subsection (2) exists; or
- 2414 (b) for noncompliance with the insurer's:
 - 2415 (i) minimum participation requirements; or
 - 2416 (ii) employer contribution requirements.
- 2417 (5) A small employer health benefit plan may be discontinued or nonrenewed:
 - 2418 (a) if a condition described in Subsection (2) exists; or
 - 2419 (b) for noncompliance with the insurer's employer contribution requirements.
- 2420 (6) A small employer health benefit plan may be nonrenewed:
 - 2421 (a) if a condition described in Subsection (2) exists; or
 - 2422 (b) for noncompliance with the insurer's minimum participation requirements.
- 2423 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
- 2424 discontinued if after issuance of coverage the eligible employee:
 - 2425 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
 - 2426 or
 - 2427 (ii) makes an intentional misrepresentation of material fact in connection with the
 - 2428 coverage.
- 2429 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
 - 2430 (i) 12 months after the date of discontinuance; and
 - 2431 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
 - 2432 to reenroll.
- 2433 (c) At the time the eligible employee's coverage is discontinued under Subsection
- 2434 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
- 2435 discontinued.
- 2436 (d) An eligible employee may not be discontinued under this Subsection (7) because of
- 2437 a fraud or misrepresentation that relates to health status.
- 2438 (8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue
- 2439 offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new
- 2440 business in such market in this state for a period of five years beginning on the date of
- 2441 discontinuation of the last coverage that is discontinued.
- 2442 (b) The commissioner may waive the prohibition under Subsection (8)(a) when the
- 2443 commissioner finds that waiver is in the public interest:

2444 (i) to promote competition; or
2445 (ii) to resolve inequity in the marketplace.
2446 (9) If an insurer is doing business in one established geographic service area of the
2447 state, this section applies only to the insurer's operations in that geographic service area.
2448 (10) An insurer may modify a health benefit plan for a plan sponsor only:
2449 (a) at the time of coverage renewal; and
2450 (b) if the modification is effective uniformly among all plans with a particular product
2451 or service.
2452 (11) For purposes of this section, a reference to "plan sponsor" includes a reference to
2453 the employer:
2454 (a) with respect to coverage provided to an employer member of the association; and
2455 (b) if the health benefit plan is made available by an insurer in the employer market
2456 only through:
2457 (i) an association;
2458 (ii) a trust; or
2459 (iii) a discretionary group.
2460 (12) (a) A small employer that, after purchasing a health benefit plan in the small group
2461 market, employs on average more than 50 eligible employees on each business day in a
2462 calendar year may continue to renew the health benefit plan purchased in the small group
2463 market.
2464 (b) A large employer that, after purchasing a health benefit plan in the large group
2465 market, employs on average less than 51 eligible employees on each business day in a calendar
2466 year may continue to renew the health benefit plan purchased in the large group market.
2467 (13) An insurer offering employer sponsored health benefit plans shall comply with the
2468 Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.
2469 Section 17. Section **31A-23a-102** is amended to read:
2470 **31A-23a-102. Definitions.**
2471 As used in this chapter:
2472 (1) "Bail bond producer" is as defined in Section [31A-35-102](#).
2473 (2) "Home state" means a state or territory of the United States or the District of
2474 Columbia in which an insurance producer:

- 2475 (a) maintains the insurance producer's principal:
- 2476 (i) place of residence; or
- 2477 (ii) place of business; and
- 2478 (b) is licensed to act as an insurance producer.
- 2479 (3) "Insurer" is as defined in Section 31A-1-301, except that the following persons or
- 2480 similar persons are not insurers for purposes of Part 7, Producer Controlled Insurers:
- 2481 (a) a risk retention group as defined in:
- 2482 (i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;
- 2483 (ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and
- 2484 (iii) Chapter 15, Part 2, Risk Retention Groups Act;
- 2485 (b) a residual market pool;
- 2486 (c) a joint underwriting authority or association; and
- 2487 (d) a captive insurer.
- 2488 (4) "License" is defined in Section 31A-1-301.
- 2489 (5) (a) "Managing general agent" means a person that:
- 2490 (i) manages all or part of the insurance business of an insurer, including the
- 2491 management of a separate division, department, or underwriting office;
- 2492 (ii) acts as an agent for the insurer whether it is known as a managing general agent,
- 2493 manager, or other similar term;
- 2494 (iii) produces and underwrites an amount of gross direct written premium equal to, or
- 2495 more than, 5% of[;] the policyholder surplus as reported in the last annual statement of the
- 2496 insurer in any one quarter or year:
- 2497 (A) with or without the authority;
- 2498 (B) separately or together with an affiliate; and
- 2499 (C) directly or indirectly; and
- 2500 (iv) (A) adjusts or pays claims in excess of an amount determined by the
- 2501 commissioner; or
- 2502 (B) negotiates reinsurance on behalf of the insurer.
- 2503 (b) Notwithstanding Subsection (5)(a), the following persons may not be considered as
- 2504 managing general agent for the purposes of this chapter:
- 2505 (i) an employee of the insurer;

- 2506 (ii) a United States manager of the United States branch of an alien insurer;
- 2507 (iii) an underwriting manager that, pursuant to contract:
- 2508 (A) manages all the insurance operations of the insurer;
- 2509 (B) is under common control with the insurer;
- 2510 (C) is subject to Chapter 16, Insurance Holding Companies; and
- 2511 (D) is not compensated based on the volume of premiums written; and
- 2512 (iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal
- 2513 insurer or inter-insurance exchange under powers of attorney.
- 2514 (6) "Negotiate" means the act of conferring directly with or offering advice directly to a
- 2515 purchaser or prospective purchaser of a particular contract of insurance concerning a
- 2516 substantive benefit, term, or condition of the contract if the person engaged in that act:
- 2517 (a) sells insurance; or
- 2518 (b) obtains insurance from insurers for purchasers.
- 2519 (7) "Reinsurance intermediary" means:
- 2520 (a) a reinsurance intermediary-broker; or
- 2521 (b) a reinsurance intermediary-manager.
- 2522 (8) "Reinsurance intermediary-broker" means a person other than an officer or
- 2523 employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or
- 2524 places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority
- 2525 or power to bind reinsurance on behalf of the insurer.
- 2526 (9) (a) "Reinsurance intermediary-manager" means a person who:
- 2527 (i) has authority to bind or who manages all or part of the assumed reinsurance
- 2528 business of a reinsurer, including the management of a separate division, department, or
- 2529 underwriting office; and
- 2530 (ii) acts as an agent for the reinsurer whether the person is known as a reinsurance
- 2531 intermediary-manager, manager, or other similar term.
- 2532 (b) Notwithstanding Subsection (9)(a), the following persons may not be considered
- 2533 reinsurance intermediary-managers for the purpose of this chapter with respect to the reinsurer:
- 2534 (i) an employee of the reinsurer;
- 2535 (ii) a United States manager of the United States branch of an alien reinsurer;
- 2536 (iii) an underwriting manager that, pursuant to contract:

- 2537 (A) manages all the reinsurance operations of the reinsurer;
- 2538 (B) is under common control with the reinsurer;
- 2539 (C) is subject to Chapter 16, Insurance Holding Companies; and
- 2540 (D) is not compensated based on the volume of premiums written; and
- 2541 (iv) the manager of a group, association, pool, or organization of insurers that:
- 2542 (A) engage in joint underwriting or joint reinsurance; and
- 2543 (B) are subject to examination by the insurance commissioner of the state in which the
- 2544 manager's principal business office is located.

2545 (10) "Resident" is as defined by rule made by the commissioner in accordance with

2546 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2547 ~~[(10)]~~ (11) "Search" means a license subline of authority in conjunction with the title

2548 insurance line of authority that allows a person to issue title insurance commitments or policies

2549 on behalf of a title insurer.

2550 ~~[(11)]~~ (12) "Sell" means to exchange a contract of insurance:

- 2551 (a) by any means;
- 2552 (b) for money or its equivalent; and
- 2553 (c) on behalf of an insurance company.

2554 ~~[(12)]~~ (13) "Solicit" means:

- 2555 (a) attempting to sell insurance;
- 2556 (b) asking or urging a person to apply for:
 - 2557 (i) a particular kind of insurance; and
 - 2558 (ii) insurance from a particular insurance company;
- 2559 (c) advertising insurance, including advertising for the purpose of obtaining leads for
- 2560 the sale of insurance; or
- 2561 (d) holding oneself out as being in the insurance business.

2562 ~~[(13)]~~ (14) "Terminate" means:

- 2563 (a) the cancellation of the relationship between:
 - 2564 (i) an individual licensee or agency licensee and a particular insurer; or
 - 2565 (ii) an individual licensee and a particular agency licensee; or
- 2566 (b) the termination of:
 - 2567 (i) an individual licensee's or agency licensee's authority to transact insurance on behalf

2568 of a particular insurance company; or

2569 (ii) an individual licensee's authority to transact insurance on behalf of a particular
2570 agency licensee.

2571 [~~(14)~~] (15) "Title marketing representative" means a person who:

2572 (a) represents a title insurer in soliciting, requesting, or negotiating the placing of:

2573 (i) title insurance; or

2574 (ii) escrow services; and

2575 (b) does not have a search or escrow license as provided in Section 31A-23a-106.

2576 [~~(15)~~] (16) "Uniform application" means the version of the National Association of
2577 Insurance Commissioners' uniform application for resident and nonresident producer licensing
2578 at the time the application is filed.

2579 [~~(16)~~] (17) "Uniform business entity application" means the version of the National
2580 Association of Insurance Commissioners' uniform business entity application for resident and
2581 nonresident business entities at the time the application is filed.

2582 Section 18. Section 31A-23a-104 is amended to read:

2583 **31A-23a-104. Application for individual license -- Application for agency license.**

2584 (1) This section applies to an initial or renewal license as a:

2585 (a) producer;

2586 (b) surplus lines producer;

2587 (c) limited line producer;

2588 (d) consultant;

2589 (e) managing general agent; or

2590 (f) reinsurance intermediary.

2591 (2) (a) Subject to Subsection (2)(b), to obtain or renew an individual license, an
2592 individual shall:

2593 (i) file an application for an initial or renewal individual license with the commissioner
2594 on forms and in a manner the commissioner prescribes; and

2595 (ii) pay a license fee that is not refunded if the application:

2596 (A) is denied; or

2597 (B) is incomplete when filed and is never completed by the applicant.

2598 (b) An application described in this Subsection (2) shall provide:

2599 (i) information about the applicant's identity;
2600 (ii) the applicant's Social Security number;
2601 (iii) the applicant's personal history, experience, education, and business record;
2602 (iv) whether the applicant is 18 years of age or older;
2603 (v) whether the applicant has committed an act that is a ground for denial, suspension,
2604 or revocation as set forth in Section 31A-23a-105 or 31A-23a-111;
2605 (vi) if the application is for a resident individual producer license, certification that the
2606 applicant complies with Section 31A-23a-203.5; and
2607 (vii) any other information the commissioner reasonably requires.
2608 (3) The commissioner may require a document reasonably necessary to verify the
2609 information contained in an application filed under this section.
2610 (4) An applicant's Social Security number contained in an application filed under this
2611 section is a private record under Section 63G-2-302.
2612 (5) (a) Subject to Subsection (5)(b), to obtain or renew an agency license, a person
2613 shall:
2614 (i) file an application for an initial or renewal agency license with the commissioner on
2615 forms and in a manner the commissioner prescribes; and
2616 (ii) pay a license fee that is not refunded if the application:
2617 (A) is denied; or
2618 (B) is incomplete when filed and is never completed by the applicant.
2619 (b) An application described in Subsection (5)(a) shall provide:
2620 (i) information about the applicant's identity;
2621 (ii) the applicant's federal employer identification number;
2622 (iii) the designated responsible licensed [~~producer~~] individual;
2623 (iv) the identity of the owners, partners, officers, and directors;
2624 (v) whether the applicant has committed an act that is a ground for denial, suspension,
2625 or revocation as set forth in Section 31A-23a-105 or 31A-23a-111; and
2626 (vi) any other information the commissioner reasonably requires.
2627 Section 19. Section 31A-23a-105 is amended to read:
2628 **31A-23a-105. General requirements for individual and agency license issuance**
2629 **and renewal.**

2630 (1) (a) The commissioner shall issue or renew a license to a person described in
2631 Subsection (1)(b) to act as:
2632 (i) a producer;
2633 (ii) a surplus lines producer;
2634 (iii) a limited line producer;
2635 (iv) a consultant;
2636 (v) a managing general agent; or
2637 (vi) a reinsurance intermediary.
2638 (b) The commissioner shall issue or renew a license under Subsection (1)(a) to a
2639 person who, as to the license type and line of authority classification applied for under Section
2640 31A-23a-106:
2641 (i) satisfies the application requirements under Section 31A-23a-104;
2642 (ii) satisfies the character requirements under Section 31A-23a-107;
2643 (iii) satisfies [any] applicable continuing education requirements under Section
2644 31A-23a-202;
2645 (iv) satisfies [any] applicable examination requirements under Section 31A-23a-108;
2646 (v) satisfies [any] applicable training period requirements under Section 31A-23a-203;
2647 (vi) if an applicant for a resident individual producer license, certifies that, to the extent
2648 applicable, the applicant:
2649 (A) is in compliance with Section 31A-23a-203.5; and
2650 (B) will maintain compliance with Section 31A-23a-203.5 during the period for which
2651 the license is issued or renewed;
2652 (vii) has not committed an act that is a ground for denial, suspension, or revocation as
2653 provided in Section 31A-23a-111;
2654 (viii) if a nonresident:
2655 (A) complies with Section 31A-23a-109; and
2656 (B) holds an active similar license in that person's home state [~~of residence~~];
2657 (ix) if an applicant for an individual title insurance producer or agency title insurance
2658 producer license, satisfies the requirements of Section 31A-23a-204;
2659 (x) if an applicant for a license to act as a life settlement provider or life settlement
2660 producer, satisfies the requirements of Section 31A-23a-117; and

- 2661 (xi) pays the applicable fees under Section 31A-3-103.
- 2662 (2) (a) This Subsection (2) applies to the following persons:
- 2663 (i) an applicant for a pending:
- 2664 (A) individual or agency producer license;
- 2665 (B) surplus lines producer license;
- 2666 (C) limited line producer license;
- 2667 (D) consultant license;
- 2668 (E) managing general agent license; or
- 2669 (F) reinsurance intermediary license; or
- 2670 (ii) a licensed:
- 2671 (A) individual or agency producer;
- 2672 (B) surplus lines producer;
- 2673 (C) limited line producer;
- 2674 (D) consultant;
- 2675 (E) managing general agent; or
- 2676 (F) reinsurance intermediary.
- 2677 (b) A person described in Subsection (2)(a) shall report to the commissioner:
- 2678 (i) an administrative action taken against the person, including a denial of a new or
- 2679 renewal license application:
- 2680 (A) in another jurisdiction; or
- 2681 (B) by another regulatory agency in this state; and
- 2682 (ii) a criminal prosecution taken against the person in any jurisdiction.
- 2683 (c) The report required by Subsection (2)(b) shall:
- 2684 (i) be filed:
- 2685 (A) at the time the person files the application for an individual or agency license; and
- 2686 (B) for an action or prosecution that occurs on or after the day on which the person
- 2687 files the application:
- 2688 (I) for an administrative action, within 30 days of the final disposition of the
- 2689 administrative action; or
- 2690 (II) for a criminal prosecution, within 30 days of the initial appearance before a court;
- 2691 and

2692 (ii) include a copy of the complaint or other relevant legal documents related to the
2693 action or prosecution described in Subsection (2)(b).

2694 (3) (a) The department may require a person applying for a license or for consent to
2695 engage in the business of insurance to submit to a criminal background check as a condition of
2696 receiving a license or consent.

2697 (b) A person, if required to submit to a criminal background check under Subsection
2698 (3)(a), shall:

2699 (i) submit a fingerprint card in a form acceptable to the department; and

2700 (ii) consent to a fingerprint background check by:

2701 (A) the Utah Bureau of Criminal Identification; and

2702 (B) the Federal Bureau of Investigation.

2703 (c) For a person who submits a fingerprint card and consents to a fingerprint
2704 background check under Subsection (3)(b), the department may request:

2705 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part
2706 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

2707 (ii) complete Federal Bureau of Investigation criminal background checks through the
2708 national criminal history system.

2709 (d) Information obtained by the department from the review of criminal history records
2710 received under this Subsection (3) shall be used by the department for the purposes of:

2711 (i) determining if a person satisfies the character requirements under Section
2712 [31A-23a-107](#) for issuance or renewal of a license;

2713 (ii) determining if a person has failed to maintain the character requirements under
2714 Section [31A-23a-107](#); and

2715 (iii) preventing a person who violates the federal Violent Crime Control and Law
2716 Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in
2717 the state.

2718 (e) If the department requests the criminal background information, the department
2719 shall:

2720 (i) pay to the Department of Public Safety the costs incurred by the Department of
2721 Public Safety in providing the department criminal background information under Subsection
2722 (3)(c)(i);

2723 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
2724 of Investigation in providing the department criminal background information under
2725 Subsection (3)(c)(ii); and

2726 (iii) charge the person applying for a license or for consent to engage in the business of
2727 insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).

2728 (4) To become a resident licensee in accordance with Section [31A-23a-104](#) and this
2729 section, a person licensed as one of the following in another state who moves to this state shall
2730 apply within 90 days of establishing legal residence in this state:

2731 (a) insurance producer;

2732 (b) surplus lines producer;

2733 (c) limited line producer;

2734 (d) consultant;

2735 (e) managing general agent; or

2736 (f) reinsurance intermediary.

2737 (5) (a) The commissioner may deny a license application for a license listed in
2738 Subsection (5)(b) if the person applying for the license, as to the license type and line of
2739 authority classification applied for under Section [31A-23a-106](#):

2740 (i) fails to satisfy the requirements as set forth in this section; or

2741 (ii) commits an act that is grounds for denial, suspension, or revocation as set forth in
2742 Section [31A-23a-111](#).

2743 (b) This Subsection (5) applies to the following licenses:

2744 (i) producer;

2745 (ii) surplus lines producer;

2746 (iii) limited line producer;

2747 (iv) consultant;

2748 (v) managing general agent; or

2749 (vi) reinsurance intermediary.

2750 (6) Notwithstanding the other provisions of this section, the commissioner may:

2751 (a) issue a license to an applicant for a license for a title insurance line of authority only
2752 with the concurrence of the Title and Escrow Commission; and

2753 (b) renew a license for a title insurance line of authority only with the concurrence of

2754 the Title and Escrow Commission.

2755 Section 20. Section **31A-23a-108** is amended to read:

2756 **31A-23a-108. Examination requirements.**

2757 (1) (a) The commissioner may require [~~applicants~~] an applicant for [~~any~~] a particular
2758 license type under Section **31A-23a-106** to pass a line of authority examination as a
2759 requirement for a license, except that an examination may not be required of [~~applicants~~] an
2760 applicant for:

2761 (i) [~~licenses~~] a license under Subsection **31A-23a-106**(2)(c); or

2762 (ii) [~~other~~] another limited line license [~~lines~~] line of authority recognized by the
2763 commissioner or the Title and Escrow Commission by rule as provided in Subsection
2764 **31A-23a-106**(3).

2765 (b) The examination described in Subsection (1)(a):

2766 (i) shall reasonably relate to the line of authority for which it is prescribed; and

2767 (ii) may be administered by the commissioner or as otherwise specified by rule.

2768 (2) The commissioner shall waive the requirement of an examination for a nonresident
2769 applicant who:

2770 (a) applies for an insurance producer license in this state within 90 days of establishing
2771 legal residence in this state;

2772 (b) has been licensed for the same line of authority in another state; and

2773 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
2774 applies for an insurance producer license in this state; or

2775 (ii) if the application is received within 90 days of the cancellation of the applicant's
2776 previous license:

2777 (A) the prior state certifies that at the time of cancellation, the applicant was in good
2778 standing in that state; or

2779 (B) the state's producer database records maintained by the National Association of
2780 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
2781 subsidiaries, indicates that the producer is or was licensed in good standing for the line of
2782 authority requested.

2783 [~~(3) A nonresident producer licensee who moves to this state and applies for a resident~~
2784 ~~license within 90 days of establishing legal residence in this state shall be exempt from any line~~

2785 of authority examination that the producer was authorized on the producer's nonresident
2786 producer license, except where the commissioner determines otherwise by rule.]

2787 [~~(4)~~] (3) This section's requirement may only be applied to [~~applicants who are natural~~
2788 ~~persons~~] an applicant who is a natural person.

2789 Section 21. Section **31A-23a-112** is amended to read:

2790 **31A-23a-112. Probation -- Grounds for revocation.**

2791 (1) The commissioner may place a licensee on probation for a period not to exceed 24
2792 months as follows:

2793 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
2794 Procedures Act, for [~~any~~] circumstances that would justify a suspension under Section
2795 **31A-23a-111**; or

2796 (b) at the issuance or renewal of a [~~new~~] license:

2797 (i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or

2798 (ii) with a response to background information questions on a new or renewal license
2799 application [~~indicating that~~] or information received from a background check conducted in
2800 connection with a new or renewal license application that indicates:

2801 (A) the person has been convicted of a crime, that is listed by rule made in accordance
2802 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for
2803 probation;

2804 (B) the person is currently charged with a crime, that is listed by rule made in
2805 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
2806 grounds for probation regardless of whether adjudication is withheld;

2807 (C) the person has been involved in an administrative proceeding regarding [~~any~~] a
2808 professional or occupational license; or

2809 (D) [~~any~~] a business in which the person is or was an owner, partner, officer, or
2810 director has been involved in an administrative proceeding regarding [~~any~~] a professional or
2811 occupational license.

2812 (2) The commissioner may place a licensee on probation for a specified period no
2813 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Sections~~]
2814 Sec. 1033 [~~and 1034~~].

2815 (3) The probation order shall state the conditions for retention of the license, which

2816 shall be reasonable.

2817 (4) [~~Any~~] A violation of the probation is grounds for revocation pursuant to [~~any~~] a
2818 proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

2819 Section 22. Section **31A-23a-113** is amended to read:

2820 **31A-23a-113. License lapse and voluntary surrender.**

2821 (1) (a) A license issued under this chapter shall lapse if the licensee fails to:

2822 (i) pay when due a fee under Section [31A-3-103](#);

2823 (ii) complete continuing education requirements under Section [31A-23a-202](#) before
2824 submitting the license renewal application;

2825 (iii) submit a completed renewal application as required by Section [31A-23a-104](#);

2826 (iv) submit additional documentation required to complete the licensing process as
2827 related to a specific license type or line of authority; or

2828 (v) maintain an active license in a [~~resident~~] licensee's home state if the licensee is a
2829 nonresident licensee.

2830 (b) (i) A licensee whose license lapses due to the following may request an action
2831 described in Subsection (1)(b)(ii):

2832 (A) military service;

2833 (B) voluntary service for a period of time designated by the person for whom the
2834 licensee provides voluntary service; or

2835 (C) some other extenuating circumstances, such as long-term medical disability.

2836 (ii) A licensee described in Subsection (1)(b)(i) may request:

2837 (A) reinstatement of the license no later than one year after the day on which the
2838 license lapses; and

2839 (B) waiver of any of the following imposed for failure to comply with renewal
2840 procedures:

2841 (I) an examination requirement;

2842 (II) reinstatement fees set under Section [31A-3-103](#);

2843 (III) continuing education requirements; or

2844 (IV) other sanction imposed for failure to comply with renewal procedures.

2845 (2) If a license issued under this chapter is voluntarily surrendered, the license or line
2846 of authority may be reinstated:

- 2847 (a) during the license period in which the license is voluntarily surrendered; and
- 2848 (b) no later than one year after the day on which the license is voluntarily surrendered.
- 2849 ~~[(3) A voluntarily surrendered license that is reinstated during the license period set~~
- 2850 ~~forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the~~
- 2851 ~~license complies with any applicable continuing education requirements for the period during~~
- 2852 ~~which the license was voluntarily surrendered.]~~

2853 Section 23. Section ~~31A-23a-202~~ is amended to read:

2854 **31A-23a-202. Continuing education requirements.**

2855 (1) Pursuant to this section, the commissioner shall by rule prescribe the continuing
2856 education requirements for a producer and a consultant.

2857 (2) (a) The commissioner may not state a continuing education requirement in terms of
2858 formal education.

2859 (b) The commissioner may state a continuing education requirement in terms of hours
2860 of insurance-related instruction received.

2861 (c) Insurance-related formal education may be a substitute, in whole or in part, for the
2862 hours required under Subsection (2)(b).

2863 (3) (a) The commissioner shall impose continuing education requirements in
2864 accordance with a two-year licensing period in which the licensee meets the requirements of
2865 this Subsection (3).

2866 (b) (i) Except as provided in this section, the continuing education requirements shall
2867 require:

2868 (A) that a licensee complete 24 credit hours of continuing education for every two-year
2869 licensing period;

2870 (B) that 3 of the 24 credit hours described in Subsection (3)(b)(i)(A) be ethics courses;
2871 and

2872 (C) that the licensee complete at least half of the required hours through classroom
2873 hours of insurance-related instruction.

2874 (ii) An hour of continuing education in accordance with Subsection (3)(b)(i) may be
2875 obtained through:

2876 (A) classroom attendance;

2877 (B) home study;

2878 (C) watching a video recording;

2879 (D) experience credit; or

2880 (E) another method provided by rule.

2881 (iii) (A) Notwithstanding Subsections (3)(b)(i)(A) and (B), an individual title insurance
2882 producer is required to complete 12 credit hours of continuing education for every two-year
2883 licensing period, with 3 of the credit hours being ethics courses unless the individual title
2884 insurance producer is licensed in this state as an individual title insurance producer for 20 or
2885 more consecutive years.

2886 (B) If an individual title insurance producer is licensed in this state as an individual
2887 title insurance producer for 20 or more consecutive years, the individual title insurance
2888 producer is required to complete 6 credit hours of continuing education for every two-year
2889 licensing period, with 3 of the credit hours being ethics courses.

2890 (C) Notwithstanding Subsection (3)(b)(iii)(A) or (B), an individual title insurance
2891 producer is considered to have met the continuing education requirements imposed under
2892 Subsection (3)(b)(iii)(A) or (B) if the individual title insurance producer:

2893 (I) is an active member in good standing with the Utah State Bar;

2894 (II) is in compliance with the continuing education requirements of the Utah State Bar;
2895 and

2896 (III) if requested by the department, provides the department evidence that the
2897 individual title insurance producer complied with the continuing education requirements of the
2898 Utah State Bar.

2899 (c) A licensee may obtain continuing education hours at any time during the two-year
2900 licensing period.

2901 (d) (i) A licensee is exempt from continuing education requirements under this section
2902 if:

2903 (A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;

2904 (B) the license does not have a continuous lapse for a period of more than one year,
2905 except for a license for which the licensee has had an exemption approved before May 11,
2906 2011;

2907 (C) the licensee requests an exemption from the department; and

2908 (D) the department approves the exemption.

2909 (ii) If the department approves the exemption under Subsection (3)(d)(i), the licensee is
2910 not required to apply again for the exemption.

2911 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
2912 commissioner shall, by rule:

2913 (i) publish a list of insurance professional designations whose continuing education
2914 requirements can be used to meet the requirements for continuing education under Subsection
2915 (3)(b);

2916 (ii) authorize a continuing education provider or a state or national professional
2917 producer or consultant association to:

2918 (A) offer a qualified program for a license type or line of authority on a geographically
2919 accessible basis; and

2920 (B) collect a reasonable fee for funding and administration of a continuing education
2921 program, subject to the review and approval of the commissioner; and

2922 (iii) provide that membership by a producer or consultant in a state or national
2923 professional producer or consultant association is considered a substitute for the equivalent of
2924 two hours for each year during which the producer or consultant is a member of the
2925 professional association, except that the commissioner may not give more than two hours of
2926 continuing education credit in a year regardless of the number of professional associations of
2927 which the producer or consultant is a member.

2928 (f) A fee permitted under Subsection (3)(e)(ii)(B) that is charged for attendance at a
2929 professional producer or consultant association program may be less for an association
2930 member, on the basis of the member's affiliation expense, but shall preserve the right of a
2931 nonmember to attend without affiliation.

2932 (4) The commissioner shall approve a continuing education provider or continuing
2933 education course that satisfies the requirements of this section.

2934 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
2935 commissioner shall by rule set the processes and procedures for continuing education provider
2936 registration and course approval.

2937 (6) The requirements of this section apply only to a producer or consultant who is an
2938 individual.

2939 (7) A nonresident producer or consultant is considered to have satisfied this state's

2940 continuing education requirements if the nonresident producer or consultant satisfies the
2941 nonresident producer's or consultant's home state's continuing education requirements for a
2942 licensed insurance producer or consultant.

2943 (8) A producer or consultant subject to this section shall keep documentation of
2944 completing the continuing education requirements of this section for two years after the end of
2945 the two-year licensing period to which the continuing education applies.

2946 Section 24. Section **31A-23a-203** is amended to read:

2947 **31A-23a-203. Training period requirements.**

2948 (1) A producer is eligible to become a surplus lines producer only if the producer:

2949 (a) has passed the applicable surplus lines producer examination;

2950 (b) has been a producer with property ~~and~~ or casualty or both lines of authority for at
2951 least three years during the four years immediately preceding the date of application; and

2952 (c) has paid the applicable fee under Section [31A-3-103](#).

2953 (2) A person is eligible to become a consultant only if the person has acted in a
2954 capacity that would provide the person with preparation to act as an insurance consultant for a
2955 period aggregating not less than three years during the four years immediately preceding the
2956 date of application.

2957 (3) (a) A resident producer with an accident and health line of authority may only sell
2958 long-term care insurance if the producer:

2959 (i) initially completes a minimum of three hours of long-term care training before
2960 selling long-term care coverage; and

2961 (ii) after completing the training required by Subsection (3)(a)(i), completes a
2962 minimum of three hours of long-term care training during each subsequent two-year licensing
2963 period.

2964 (b) A course taken to satisfy a long-term care training requirement may be used toward
2965 satisfying a producer continuing education requirement.

2966 (c) Long-term care training is not a continuing education requirement to renew a
2967 producer license.

2968 (d) An insurer that issues long-term care insurance shall demonstrate to the
2969 commissioner, upon request, that a producer who is appointed by the insurer and who sells
2970 long-term care insurance coverage is in compliance with this Subsection (3).

2971 (4) The training periods required under this section apply only to an individual
2972 applying for a license under this chapter.

2973 Section 25. Section **31A-23a-402.5** is amended to read:

2974 **31A-23a-402.5. Inducements.**

2975 (1) (a) Except as provided in Subsection (2), a producer, consultant, or other licensee
2976 under this title, or an officer or employee of a licensee, may not induce a person to enter into,
2977 continue, or terminate an insurance contract by offering a benefit that is not:

2978 (i) specified in the insurance contract; or

2979 (ii) directly related to the insurance contract.

2980 (b) An insurer may not make or knowingly allow an agreement of insurance that is not
2981 clearly expressed in the insurance contract to be issued or renewed.

2982 (c) A licensee under this title may not absorb the tax under Section **31A-3-301**.

2983 (2) This section does not apply to a title insurer, an individual title insurance producer,
2984 or agency title insurance producer, or an officer or employee of a title insurer, an individual
2985 title insurance producer, or an agency title insurance producer.

2986 (3) Items not prohibited by Subsection (1) include an insurer:

2987 (a) reducing premiums because of expense savings;

2988 (b) providing to a policyholder or insured one or more incentives, as defined by the
2989 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
2990 Rulemaking Act, to participate in a program or activity designed to reduce claims or claim
2991 expenses, including:

2992 (i) a premium discount offered to a small or large employer group based on a wellness
2993 program if:

2994 (A) the premium discount for the employer group does not exceed 20% of the group
2995 premium; and

2996 (B) the premium discount based on the wellness program is offered uniformly by the
2997 insurer to all employer groups in the large or small group market;

2998 (ii) a premium discount offered to employees of a small or large employer group in an
2999 amount that does not exceed federal limits on wellness program incentives; or

3000 (iii) a combination of premium discounts offered to the employer group and the
3001 employees of an employer group, based on a wellness program, if:

3002 (A) the premium discounts for the employer group comply with Subsection (3)(b)(i);
3003 and

3004 (B) the premium discounts for the employees of an employer group comply with
3005 Subsection (3)(b)(ii); or

3006 (c) receiving premiums under an installment payment plan.

3007 (4) Items not prohibited by Subsection (1) include a producer, consultant, or other
3008 licensee, or an officer or employee of a licensee, either directly or through a third party:

3009 (a) engaging in a usual kind of social courtesy if receipt of the social courtesy is not
3010 conditioned on a quote or the purchase of a particular insurance product;

3011 (b) extending credit on a premium to the insured:

3012 (i) without interest, for no more than 90 days from the effective date of the insurance
3013 contract;

3014 (ii) for interest that is not less than the legal rate under Section 15-1-1, on the unpaid
3015 balance after the time period described in Subsection (4)(b)(i); and

3016 (iii) except that an installment or payroll deduction payment of premiums on an
3017 insurance contract issued under an insurer's mass marketing program is not considered an
3018 extension of credit for purposes of this Subsection (4)(b);

3019 (c) preparing or conducting a survey that:

3020 (i) is directly related to an accident and health insurance policy purchased from the
3021 licensee; or

3022 (ii) is used by the licensee to assess the benefit needs and preferences of insureds,
3023 employers, or employees directly related to an insurance product sold by the licensee;

3024 (d) providing limited human resource services that are directly related to an insurance
3025 product sold by the licensee, including:

3026 (i) answering questions directly related to:

3027 (A) an employee benefit offering or administration, if the insurance product purchased
3028 from the licensee is accident and health insurance or health insurance; and

3029 (B) employment practices liability, if the insurance product offered by or purchased
3030 from the licensee is property or casualty insurance; and

3031 (ii) providing limited human resource compliance training and education directly
3032 pertaining to an insurance product purchased from the licensee;

- 3033 (e) providing the following types of information or guidance:
- 3034 (i) providing guidance directly related to compliance with federal and state laws for an
- 3035 insurance product purchased from the licensee;
- 3036 (ii) providing a workshop or seminar addressing an insurance issue that is directly
- 3037 related to an insurance product purchased from the licensee; or
- 3038 (iii) providing information regarding:
- 3039 (A) employee benefit issues;
- 3040 (B) directly related insurance regulatory and legislative updates; or
- 3041 (C) similar education about an insurance product sold by the licensee and how the
- 3042 insurance product interacts with tax law;
- 3043 (f) preparing or providing a form that is directly related to an insurance product
- 3044 purchased from, or offered by, the licensee;
- 3045 (g) preparing or providing documents directly related to a premium only cafeteria plan
- 3046 within the meaning of Section 125, Internal Revenue Code, or a flexible spending account, but
- 3047 not providing ongoing administration of a flexible spending account;
- 3048 (h) providing enrollment and billing assistance, including:
- 3049 (i) providing benefit statements or new hire insurance benefits packages; and
- 3050 (ii) providing technology services such as an electronic enrollment platform or
- 3051 application system;
- 3052 (i) communicating coverages in writing and in consultation with the insured and
- 3053 employees;
- 3054 (j) providing employee communication materials and notifications directly related to an
- 3055 insurance product purchased from a licensee;
- 3056 (k) providing claims management and resolution to the extent permitted under the
- 3057 licensee's license;
- 3058 (l) providing underwriting or actuarial analysis or services;
- 3059 (m) negotiating with an insurer regarding the placement and pricing of an insurance
- 3060 product;
- 3061 (n) recommending placement and coverage options;
- 3062 (o) providing a health fair or providing assistance or advice on establishing or
- 3063 operating a wellness program, but not providing any payment for or direct operation of the

3064 wellness program;

3065 (p) providing COBRA and Utah mini-COBRA administration, consultations, and other
3066 services directly related to an insurance product purchased from the licensee;

3067 (q) assisting with a summary plan description, including providing a summary plan
3068 description wraparound;

3069 (r) providing information necessary for the preparation of documents directly related to
3070 the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq., as
3071 amended;

3072 (s) providing information or services directly related to the Health Insurance Portability
3073 and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended, such as services
3074 directly related to health care access, portability, and renewability when offered in connection
3075 with accident and health insurance sold by a licensee;

3076 (t) sending proof of coverage to a third party with a legitimate interest in coverage;

3077 (u) providing information in a form approved by the commissioner and directly related
3078 to determining whether an insurance product sold by the licensee meets the requirements of a
3079 third party contract that requires or references insurance coverage;

3080 (v) facilitating risk management services directly related to property and casualty
3081 insurance products sold or offered for sale by the licensee, including:

3082 (i) risk management;

3083 (ii) claims and loss control services;

3084 (iii) risk assessment consulting, including analysis of:

3085 (A) employer's job descriptions; or

3086 (B) employer's safety procedures or manuals; and

3087 (iv) providing information and training on best practices;

3088 (w) otherwise providing services that are legitimately part of servicing an insurance
3089 product purchased from a licensee; and

3090 (x) providing other directly related services approved by the department.

3091 (5) An inducement prohibited under Subsection (1) includes a producer, consultant, or
3092 other licensee, or an officer or employee of a licensee:

3093 (a) (i) providing a premium or commission rebate;

3094 (ii) paying the salary of an employee of a person who purchases an insurance product

3095 from the licensee; or

3096 (iii) if the licensee is an insurer, or a third party administrator who contracts with an

3097 insurer, paying the salary for an onsite staff member to perform an act prohibited under

3098 Subsection (5)(b)(xii); or

3099 (b) engaging in one or more of the following unless a fee is paid in accordance with

3100 Subsection (8):

3101 (i) performing background checks of prospective employees;

3102 (ii) providing legal services by a person licensed to practice law;

3103 (iii) performing drug testing that is directly related to an insurance product purchased

3104 from the licensee;

3105 (iv) preparing employer or employee handbooks, except that a licensee may:

3106 (A) provide information for a medical benefit section of an employee handbook;

3107 (B) provide information for the section of an employee handbook directly related to an

3108 employment practices liability insurance product purchased from the licensee; or

3109 (C) prepare or print an employee benefit enrollment guide;

3110 (v) providing job descriptions, postings, and applications for a person;

3111 (vi) providing payroll services;

3112 (vii) providing performance reviews or performance review training;

3113 (viii) providing union advice;

3114 (ix) providing accounting services;

3115 (x) providing data analysis information technology programs, except as provided in

3116 Subsection (4)(h)(ii);

3117 (xi) providing administration of health reimbursement accounts or health savings

3118 accounts; or

3119 (xii) if the licensee is an insurer, or a third party administrator who contracts with an

3120 insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of

3121 the following prohibited benefits:

3122 (A) performing background checks of prospective employees;

3123 (B) providing legal services by a person licensed to practice law;

3124 (C) performing drug testing that is directly related to an insurance product purchased

3125 from the insurer;

- 3126 (D) preparing employer or employee handbooks;
 - 3127 (E) providing job descriptions postings, and applications;
 - 3128 (F) providing payroll services;
 - 3129 (G) providing performance reviews or performance review training;
 - 3130 (H) providing union advice;
 - 3131 (I) providing accounting services;
 - 3132 (J) providing discrimination testing; or
 - 3133 (K) providing data analysis information technology programs.
- 3134 (6) A producer, consultant, or other licensee or an officer or employee of a licensee
3135 shall itemize and bill separately from any other insurance product or service offered or
3136 provided under Subsection (5)(b).
- 3137 (7) (a) A de minimis gift or meal not to exceed \$25 for each individual receiving the
3138 gift or meal is presumed to be a social courtesy not conditioned on a quote or purchase of a
3139 particular insurance product for purposes of Subsection (4)(a).
- 3140 (b) Notwithstanding Subsection (4)(a), a de minimis gift or meal not to exceed \$10
3141 may be conditioned on receipt of a quote of a particular insurance product [~~if the de minimis~~
3142 ~~gift or meal is provided by the insurer and not by a producer or consultant~~].
- 3143 (8) If as provided under Subsection (5)(b) a producer, consultant, or other licensee is
3144 paid a fee to provide an item listed in Subsection (5)(b), the licensee shall comply with
3145 Subsection 31A-23a-501(2) in charging the fee, except that the fee paid for the item shall equal
3146 or exceed the fair market value of the item.
- 3147 Section 26. Section 31A-23b-102 is amended to read:
- 3148 **31A-23b-102. Definitions.**
- 3149 As used in this chapter:
- 3150 (1) "Compensation" is as defined in:
 - 3151 (a) Subsections 31A-23a-501(1)(a), (b), and (d); and
 - 3152 (b) PPACA.
 - 3153 (2) "Enroll" and "enrollment" mean to:
 - 3154 (a) (i) obtain personally identifiable information about an individual; and
 - 3155 (ii) inform an individual about accident and health insurance plans or public programs
3156 offered on an exchange;

3157 (b) solicit insurance; or

3158 (c) submit to the exchange:

3159 (i) personally identifiable information about an individual; and

3160 (ii) an individual's selection of a particular accident and health insurance plan or public

3161 program offered on the exchange.

3162 (3) (a) "Exchange" means an online marketplace~~[(i) for an individual to purchase a~~

3163 ~~qualified health plan; and (ii)]~~ that is certified by the United States Department of Health and

3164 Human Services as either a state-based small employer exchange or a federally facilitated

3165 individual exchange under PPACA.

3166 (b) ~~[(i)]~~ "Exchange" does not include~~[(A)]~~ an online marketplace for the purchase of

3167 health insurance if the online marketplace is not a certified exchange ~~[under PPACA; or]~~ in

3168 accordance with Subsection (3)(a).

3169 ~~[(B) except as provided in Subsection (3)(b)(ii), an online marketplace for small~~

3170 ~~employers that is certified as a PPACA compliant SHOP exchange.]~~

3171 ~~[(ii) For purposes of this chapter, exchange does include a small employer SHOP~~

3172 ~~exchange described under Subsection (3)(b)(i)(B) if:]~~

3173 ~~[(A) federal regulations under PPACA require a small employer exchange to allow~~

3174 ~~navigators to assist small employers and their employees with selection of qualified health~~

3175 ~~plans on a small employer exchange; and]~~

3176 ~~[(B) the state has not entered into an agreement with the United States Department of~~

3177 ~~Health and Human Services that permits the state to limit the scope of practice of navigators to~~

3178 ~~only the individual PPACA exchange.]~~

3179 (4) "Navigator":

3180 (a) means a person who facilitates enrollment in an exchange by offering to assist, or

3181 who advertises any services to assist, with:

3182 (i) the selection of and enrollment in a qualified health plan or a public program

3183 offered on an exchange; or

3184 (ii) applying for premium subsidies through an exchange; and

3185 (b) includes a person who is an in-person assister or ~~[an]~~ a certified application

3186 ~~[assister]~~ counselor as described in~~[(i)]~~ federal regulations or guidance issued under PPACA~~;~~

3187 and].

3188 ~~[(ii) the state exchange blueprint published by the Center for Consumer Information~~
3189 ~~and Insurance Oversight within the Centers for Medicare and Medicaid Services in the United~~
3190 ~~States Department of Health and Human Services.]~~

3191 (5) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

3192 (6) "Public programs" means the state Medicaid program in Title 26, Chapter 18,
3193 Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

3194 (7) "Resident" is as defined by rule made by the commissioner in accordance with Title
3195 63G, Chapter 3, Utah Administrative Rulemaking Act.

3196 ~~[(7)]~~ (8) "Solicit" is as defined in Section 31A-23a-102.

3197 Section 27. Section 31A-23b-202 is amended to read:

3198 **31A-23b-202. Qualifications for a license.**

3199 (1) (a) The commissioner shall issue or renew a license to a person to act as a navigator
3200 if the person:

3201 (i) satisfies the:

3202 (A) application requirements under Section 31A-23b-203;

3203 (B) character requirements under Section 31A-23b-204;

3204 (C) examination and training requirements under Section 31A-23b-205; and

3205 (D) continuing education requirements under Section 31A-23b-206;

3206 (ii) certifies that, to the extent applicable, the applicant:

3207 (A) is in compliance with the surety bond requirements of Section 31A-23b-207; and

3208 (B) will maintain compliance with Section 31A-23b-207 during the period for which
3209 the license is issued or renewed; and

3210 (iii) has not committed an act that is a ground for denial, suspension, or revocation as
3211 provided in Section 31A-23b-401.

3212 (b) A license issued under this chapter is valid for ~~[two years]~~ one year.

3213 (2) (a) A person shall report to the commissioner:

3214 (i) an administrative action taken against the person, including a denial of a new or
3215 renewal license application:

3216 (A) in another jurisdiction; or

3217 (B) by another regulatory agency in this state; and

3218 (ii) a criminal prosecution taken against the person in any jurisdiction.

- 3219 (b) The report required by Subsection (2)(a) shall be filed:
- 3220 (i) at the time the person files the application for an individual or agency license; and
- 3221 (ii) for an action or prosecution that occurs on or after the day on which the person files
- 3222 the application:
- 3223 (A) for an administrative action, within 30 days of the final disposition of the
- 3224 administrative action; or
- 3225 (B) for a criminal prosecution, within 30 days of the initial appearance before a court.
- 3226 (c) The report required by Subsection (2)(a) shall include a copy of the complaint or
- 3227 other relevant legal documents related to the action or prosecution described in Subsection
- 3228 (2)(a).
- 3229 (3) (a) The department may:
- 3230 (i) require a person applying for a license to submit to a criminal background check as
- 3231 a condition of receiving a license; or
- 3232 (ii) accept a background check conducted by another organization.
- 3233 (b) A person, if required to submit to a criminal background check under Subsection
- 3234 (3)(a), shall:
- 3235 (i) submit a fingerprint card in a form acceptable to the department; and
- 3236 (ii) consent to a fingerprint background check by:
- 3237 (A) the Utah Bureau of Criminal Identification; and
- 3238 (B) the Federal Bureau of Investigation.
- 3239 (c) For a person who submits a fingerprint card and consents to a fingerprint
- 3240 background check under Subsection (3)(b), the department may request:
- 3241 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part
- 3242 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
- 3243 (ii) complete Federal Bureau of Investigation criminal background checks through the
- 3244 national criminal history system.
- 3245 (d) Information obtained by the department from the review of criminal history records
- 3246 received under this Subsection (3) shall be used by the department for the purposes of:
- 3247 (i) determining if a person satisfies the character requirements under Section
- 3248 [31A-23b-204](#) for issuance or renewal of a license;
- 3249 (ii) determining if a person failed to maintain the character requirements under Section

3250 31A-23b-204; and

3251 (iii) preventing a person who violates the federal Violent Crime Control and Law
3252 Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of a navigator or
3253 in-person assistor in the state.

3254 (e) If the department requests the criminal background information, the department
3255 shall:

3256 (i) pay to the Department of Public Safety the costs incurred by the Department of
3257 Public Safety in providing the department criminal background information under Subsection
3258 (3)(c)(i);

3259 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
3260 of Investigation in providing the department criminal background information under
3261 Subsection (3)(c)(ii); and

3262 (iii) charge the person applying for a license a fee equal to the aggregate of Subsections
3263 (3)(e)(i) and (ii).

3264 (4) The commissioner may deny an application for a license under this chapter if the
3265 person applying for the license:

3266 (a) fails to satisfy the requirements of this section; or

3267 (b) commits an act that is grounds for denial, suspension, or revocation as set forth in
3268 Section 31A-23b-401.

3269 Section 28. Section 31A-23b-205 is amended to read:

3270 **31A-23b-205. Examination and training requirements.**

3271 (1) The commissioner may require [~~applicants~~] an applicant for a license to pass an
3272 examination and complete a training program as a requirement for a license.

3273 (2) The examination described in Subsection (1) shall reasonably relate to:

3274 (a) the duties and functions of a navigator;

3275 (b) requirements for navigators as established by federal regulation under PPACA; and

3276 (c) other requirements that may be established by the commissioner by administrative
3277 rule.

3278 (3) The examination may be administered by the commissioner or as otherwise
3279 specified by administrative rule.

3280 (4) The training required by Subsection (1) shall be approved by the commissioner and

3281 shall include:

- 3282 (a) accident and health insurance plans;
- 3283 (b) qualifications for and enrollment in public programs;
- 3284 (c) qualifications for and enrollment in premium subsidies;
- 3285 (d) cultural and linguistic competence;
- 3286 (e) conflict of interest standards;
- 3287 (f) exchange functions; and
- 3288 (g) other requirements that may be adopted by the commissioner by administrative

3289 rule.

3290 (5) The training required by Subsection (1) shall consist of:

- 3291 (a) at least 21 credit hours of training before obtaining a license;
- 3292 (b) at least 1 of the 21 credit hours of training described in Subsection (5)(a) on defined
- 3293 contribution arrangement and the small employer Health Insurance Exchange created in
- 3294 accordance with Title 63M, Chapter 1, Part 25, Health System Reform Act; and
- 3295 (c) the navigator training and certification program developed by the Centers for
- 3296 Medicare and Medicaid Services.

3297 ~~[(5)]~~ (6) This section applies only to [applicants who are natural persons] an applicant

3298 who is a natural person.

3299 Section 29. Section **31A-23b-206** is amended to read:

3300 **31A-23b-206. Continuing education requirements.**

3301 (1) The commissioner shall, by rule, prescribe continuing education requirements for a

3302 navigator.

3303 (2) (a) The commissioner may not require a degree from an institution of higher

3304 education as part of continuing education.

3305 (b) The commissioner may state a continuing education requirement in terms of hours

3306 of instruction received in:

- 3307 (i) accident and health insurance;
- 3308 (ii) qualification for and enrollment in public programs;
- 3309 (iii) qualification for and enrollment in premium subsidies;
- 3310 (iv) cultural competency;
- 3311 (v) conflict of interest standards; and

3312 (vi) other exchange functions.

3313 (3) (a) Continuing education requirements shall require:

3314 (i) that a licensee complete ~~[24]~~ 12 credit hours of continuing education for every

3315 ~~[two-year]~~ one-year licensing period;

3316 (ii) that ~~[3]~~ at least 2 of the ~~[24]~~ 12 credit hours described in Subsection (3)(a)(i) be

3317 ethics courses; ~~[and]~~

3318 ~~[(iii) that the licensee complete at least half of the required hours through classroom~~

3319 ~~hours of insurance and exchange related instruction.]~~

3320 (iii) that at least 1 of the 12 credit hours described in Subsection (3)(a)(i) be a defined

3321 contribution course that includes training on use of the Health Insurance Exchange; and

3322 (iv) that a licensee complete the annual navigator training and certification program

3323 developed by the Centers for Medicare and Medicaid Services.

3324 (b) An hour of continuing education in accordance with Subsection (3)(a)(i) may be

3325 obtained through:

3326 (i) classroom attendance;

3327 (ii) home study;

3328 (iii) watching a video recording; or

3329 ~~[(iv) experience credit; or]~~

3330 ~~[(v)]~~ (iv) another method approved by rule.

3331 (c) A licensee may obtain continuing education hours at any time during the ~~[two-year]~~

3332 one-year license period.

3333 (d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the

3334 commissioner shall~~;~~ by rule~~:(i) publish a list of insurance professional designations whose~~

3335 ~~continuing education requirements can be used to meet the requirements for continuing~~

3336 ~~education under Subsection (3)(b); and (ii)]~~ authorize one or more continuing education

3337 providers, including a state or national professional producer or consultant associations, to:

3338 ~~[(A)]~~ (i) offer a qualified program on a geographically accessible basis; and

3339 ~~[(B)]~~ (ii) collect a reasonable fee for funding and administration of a continuing

3340 education program, subject to the review and approval of the commissioner.

3341 (4) The commissioner shall approve a continuing education provider or a continuing

3342 education course that satisfies the requirements of this section.

3343 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3344 commissioner shall by rule establish the procedures for continuing education provider
3345 registration and course approval.

3346 (6) This section applies only to a navigator who is a natural person.

3347 (7) A navigator shall keep documentation of completing the continuing education
3348 requirements of this section for two years after the end of the [~~two-year~~] one-year licensing
3349 period to which the continuing education applies.

3350 Section 30. Section **31A-23b-301** is amended to read:

3351 **31A-23b-301. Unfair practices -- Compensation -- Limit of scope of practice.**

3352 (1) As used in this section, "false or misleading information" includes, with intent to
3353 deceive a person examining it:

3354 (a) filing a report;

3355 (b) making a false entry in a record; or

3356 (c) willfully refraining from making a proper entry in a record.

3357 (2) (a) Communication that contains false or misleading information relating to
3358 enrollment in an insurance plan or a public program, including information that is false or
3359 misleading because it is incomplete, may not be made by:

3360 (i) a person who is or should be licensed under this title;

3361 (ii) an employee of a person described in Subsection (2)(a)(i);

3362 (iii) a person whose primary interest is as a competitor of a person licensed under this
3363 title; and

3364 (iv) a person on behalf of [~~any of the persons~~] a person listed in this Subsection (2)(a).

3365 (b) A licensee under this chapter may not:

3366 (i) use [~~any~~] a business name, slogan, emblem, or related device that is misleading or
3367 likely to cause the exchange, insurer, or other licensee to be mistaken for another governmental
3368 agency, a PPACA exchange, insurer, or other licensee already in business; or

3369 (ii) use [~~any~~] an advertisement or other insurance promotional material that would
3370 cause a reasonable person to mistakenly believe that a state or federal government agency,
3371 public program, or insurer:

3372 (A) is responsible for the insurance or public program enrollment assistance activities
3373 of the person;

- 3374 (B) stands behind the credit of the person; or
- 3375 (C) is a source of payment of [any] an insurance obligation of or sold by the person.
- 3376 (c) A person who is not an insurer may not assume or use [any] a name that deceptively
- 3377 implies or suggests that person is an insurer.
- 3378 (3) A person may not engage in an unfair method of competition or any other unfair or
- 3379 deceptive act or practice in the business of insurance, as defined by the commissioner by rule,
- 3380 after a finding that the method of competition, the act, or the practice:
- 3381 (a) is misleading;
- 3382 (b) is deceptive;
- 3383 (c) is unfairly discriminatory;
- 3384 (d) provides an unfair inducement; or
- 3385 (e) unreasonably restrains competition.
- 3386 (4) A navigator licensed under this chapter is subject to the unfair marketing practices
- 3387 and inducement provisions of [Section] Sections 31A-23a-402 and 31A-23a-402.5.
- 3388 (5) A navigator licensed under this chapter or who should be licensed under this
- 3389 chapter:
- 3390 (a) may not receive direct or indirect compensation from an accident or health insurer
- 3391 or from an individual who receives services from a navigator in accordance with:
- 3392 (i) federal conflict of interest regulations established pursuant to PPACA; and
- 3393 (ii) administrative rule adopted by the department;
- 3394 (b) may be compensated by the exchange for performing the duties of a navigator;
- 3395 (c) (i) may perform, offer to perform, or advertise a service as a navigator only for a
- 3396 person selecting a qualified health plan or public program offered on an exchange; and
- 3397 (ii) may not perform, offer to perform, or advertise [any] services as a navigator for
- 3398 individuals or small employer groups selecting accident and health insurance plans, qualified
- 3399 health plans, public programs, business, or services that are not offered on an exchange; and
- 3400 (d) may not recommend a particular accident and health insurance plan or qualified
- 3401 health plan.
- 3402 Section 31. Section **31A-23b-402** is amended to read:
- 3403 **31A-23b-402. Probation -- Grounds for revocation.**
- 3404 (1) The commissioner may place a licensee on probation for a period not to exceed 24

3405 months as follows:

3406 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
3407 Procedures Act, for any circumstances that would justify a suspension under this section; or

3408 (b) at the issuance of a new license:

3409 (i) with an admitted violation under 18 U.S.C. [~~Secs.~~] Sec. 1033 [~~and 1034~~]; or

3410 (ii) with a response to background information questions on a new license application

3411 indicating that:

3412 (A) the person has been convicted of a crime that is listed by rule made in accordance
3413 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is a ground for
3414 probation;

3415 (B) the person is currently charged with a crime that is listed by rule made in
3416 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
3417 a ground for probation regardless of whether adjudication is withheld;

3418 (C) the person has been involved in an administrative proceeding regarding any
3419 professional or occupational license; or

3420 (D) any business in which the person is or was an owner, partner, officer, or director
3421 has been involved in an administrative proceeding regarding any professional or occupational
3422 license.

3423 (2) The commissioner may place a licensee on probation for a specified period no
3424 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Secs.~~] Sec.
3425 1033 [~~and 1034~~].

3426 (3) The probation order shall state the conditions for revocation or retention of the
3427 license, which shall be reasonable.

3428 (4) Any violation of the probation is a ground for revocation pursuant to any
3429 proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

3430 Section 32. Section **31A-25-208** is amended to read:

3431 **31A-25-208. Revocation, suspension, surrender, lapsing, limiting, or otherwise**
3432 **terminating a license -- Rulemaking for renewal and reinstatement.**

3433 (1) A license type issued under this chapter remains in force until:

3434 (a) revoked or suspended under Subsection (4);

3435 (b) surrendered to the commissioner and accepted by the commissioner in lieu of

3436 administrative action;

3437 (c) the licensee dies or is adjudicated incompetent as defined under:

3438 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3439 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and

3440 Minors;

3441 (d) lapsed under Section [31A-25-210](#); or

3442 (e) voluntarily surrendered.

3443 (2) The following may be reinstated within one year after the day on which the license

3444 is no longer in force:

3445 (a) a lapsed license; or

3446 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may

3447 not be reinstated after the license period in which the license is voluntarily surrendered.

3448 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a

3449 license, submission and acceptance of a voluntary surrender of a license does not prevent the

3450 department from pursuing additional disciplinary or other action authorized under:

3451 (a) this title; or

3452 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah

3453 Administrative Rulemaking Act.

3454 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an

3455 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the

3456 commissioner may:

3457 (i) revoke a license;

3458 (ii) suspend a license for a specified period of 12 months or less;

3459 (iii) limit a license in whole or in part; or

3460 (iv) deny a license application.

3461 (b) The commissioner may take an action described in Subsection (4)(a) if the

3462 commissioner finds that the licensee:

3463 (i) is unqualified for a license under Section [31A-25-202](#), [31A-25-203](#), or [31A-25-204](#);

3464 (ii) has violated:

3465 (A) an insurance statute;

3466 (B) a rule that is valid under Subsection [31A-2-201](#)(3); or

- 3467 (C) an order that is valid under Subsection 31A-2-201(4);
- 3468 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
- 3469 delinquency proceedings in any state;
- 3470 (iv) fails to pay a final judgment rendered against the person in this state within 60
- 3471 days after the day on which the judgment became final;
- 3472 (v) fails to meet the same good faith obligations in claims settlement that is required of
- 3473 admitted insurers;
- 3474 (vi) is affiliated with and under the same general management or interlocking
- 3475 directorate or ownership as another third party administrator that transacts business in this state
- 3476 without a license;
- 3477 (vii) refuses:
- 3478 (A) to be examined; or
- 3479 (B) to produce its accounts, records, and files for examination;
- 3480 (viii) has an officer who refuses to:
- 3481 (A) give information with respect to the third party administrator's affairs; or
- 3482 (B) perform any other legal obligation as to an examination;
- 3483 (ix) provides information in the license application that is:
- 3484 (A) incorrect;
- 3485 (B) misleading;
- 3486 (C) incomplete; or
- 3487 (D) materially untrue;
- 3488 (x) has violated an insurance law, valid rule, or valid order of another state's insurance
- 3489 department;
- 3490 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 3491 (xii) has improperly withheld, misappropriated, or converted money or properties
- 3492 received in the course of doing insurance business;
- 3493 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 3494 (A) insurance contract; or
- 3495 (B) application for insurance;
- 3496 (xiv) has been convicted of a felony;
- 3497 (xv) has admitted or been found to have committed an insurance unfair trade practice

3498 or fraud;

3499 (xvi) in the conduct of business in this state or elsewhere has:

3500 (A) used fraudulent, coercive, or dishonest practices; or

3501 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

3502 (xvii) has had an insurance license or its equivalent, denied, suspended, or revoked in

3503 any other state, province, district, or territory;

3504 (xviii) has forged another's name to:

3505 (A) an application for insurance; or

3506 (B) a document related to an insurance transaction;

3507 (xix) has improperly used notes or any other reference material to complete an

3508 examination for an insurance license;

3509 (xx) has knowingly accepted insurance business from an individual who is not

3510 licensed;

3511 (xxi) has failed to comply with an administrative or court order imposing a child

3512 support obligation;

3513 (xxii) has failed to:

3514 (A) pay state income tax; or

3515 (B) comply with an administrative or court order directing payment of state income

3516 tax;

3517 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and

3518 Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 [~~and 1034~~] and therefore under 18 U.S.C.

3519 Sec. 1033 is prohibited from engaging in the business of insurance; or

3520 (xxiv) has engaged in methods and practices in the conduct of business that endanger

3521 the legitimate interests of customers and the public.

3522 (c) For purposes of this section, if a license is held by an agency, both the agency itself

3523 and any individual designated under the license are considered to be the holders of the agency

3524 license.

3525 (d) If an individual designated under the agency license commits an act or fails to

3526 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,

3527 the commissioner may suspend, revoke, or limit the license of:

3528 (i) the individual;

3529 (ii) the agency if the agency:
3530 (A) is reckless or negligent in its supervision of the individual; or
3531 (B) knowingly participated in the act or failure to act that is the ground for suspending,
3532 revoking, or limiting the license; or
3533 (iii) (A) the individual; and
3534 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).
3535 (5) A licensee under this chapter is subject to the penalties for acting as a licensee
3536 without a license if:
3537 (a) the licensee's license is:
3538 (i) revoked;
3539 (ii) suspended;
3540 (iii) limited;
3541 (iv) surrendered in lieu of administrative action;
3542 (v) lapsed; or
3543 (vi) voluntarily surrendered; and
3544 (b) the licensee:
3545 (i) continues to act as a licensee; or
3546 (ii) violates the terms of the license limitation.
3547 (6) A licensee under this chapter shall immediately report to the commissioner:
3548 (a) a revocation, suspension, or limitation of the person's license in any other state, the
3549 District of Columbia, or a territory of the United States;
3550 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
3551 the District of Columbia, or a territory of the United States; or
3552 (c) a judgment or injunction entered against the person on the basis of conduct
3553 involving:
3554 (i) fraud;
3555 (ii) deceit;
3556 (iii) misrepresentation; or
3557 (iv) a violation of an insurance law or rule.
3558 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a
3559 license in lieu of administrative action may specify a time, not to exceed five years, within

3560 which the former licensee may not apply for a new license.

3561 (b) If no time is specified in the order or agreement described in Subsection (7)(a), the
3562 former licensee may not apply for a new license for five years from the day on which the order
3563 or agreement is made without the express approval of the commissioner.

3564 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
3565 a license issued under this part if so ordered by the court.

3566 (9) The commissioner shall by rule prescribe the license renewal and reinstatement
3567 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3568 Section 33. Section **31A-25-209** is amended to read:

3569 **31A-25-209. Probation -- Grounds for revocation.**

3570 (1) The commissioner may place a licensee on probation for a period not to exceed 24
3571 months as follows:

3572 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
3573 Procedures Act, for any circumstances that would justify a suspension under Section
3574 [31A-25-208](#); or

3575 (b) at the issuance of a new license:

3576 (i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or

3577 (ii) with a response to a background information question on a new license application
3578 indicating that:

3579 (A) the person has been convicted of a crime that is listed by rule made in accordance
3580 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for
3581 probation;

3582 (B) the person is currently charged with a crime that is listed by rule made in
3583 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
3584 grounds for probation regardless of whether adjudication is withheld;

3585 (C) the person has been involved in an administrative proceeding regarding any
3586 professional or occupational license; or

3587 (D) any business in which the person is or was an owner, partner, officer, or director
3588 has been involved in an administrative proceeding regarding any professional or occupational
3589 license.

3590 (2) The commissioner may place a licensee on probation for a specified period no

3591 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [Sections]
3592 Sec. 1033 [and 1034].

3593 (3) A probation order under this section shall state the conditions for retention of the
3594 license, which shall be reasonable.

3595 (4) A violation of the probation is grounds for revocation pursuant to any proceeding
3596 authorized under Title 63G, Chapter 4, Administrative Procedures Act.

3597 Section 34. Section **31A-26-102** is amended to read:

3598 **31A-26-102. Definitions.**

3599 As used in this chapter, unless expressly provided otherwise:

3600 (1) "Company adjuster" means a person employed by an insurer whose regular duties
3601 include insurance adjusting.

3602 (2) "Designated home state" means the state or territory of the United States or the
3603 District of Columbia:

3604 (a) in which an insurance adjuster does not maintain the adjuster's principal:

3605 (i) place of residence; or

3606 (ii) place of business;

3607 (b) if the resident state, territory, or District of Columbia of the adjuster does not
3608 license adjusters for the line of authority sought, the adjuster has qualified for the license as if
3609 the person were a resident in the state, territory, or District of Columbia described in
3610 Subsection (2)(a) including an applicable:

3611 (A) examination requirement;

3612 (B) fingerprint background check requirement; and

3613 (C) continuing education requirement; and

3614 (c) the adjuster has designated the state, territory, or District of Columbia as the
3615 designated home state.

3616 (3) "Home state" means:

3617 (a) a state or territory of the United States or the District of Columbia in which an
3618 insurance adjuster:

3619 (i) maintains the adjuster's principal:

3620 (A) place of residence; or

3621 (B) place of business; and

3622 (ii) is licensed to act as a resident adjuster; or
3623 (b) if the resident state, territory, or the District of Columbia described in Subsection
3624 (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District
3625 of Columbia:

3626 (i) in which the adjuster is licensed;
3627 (ii) in which the adjuster is in good standing; and
3628 (iii) that the adjuster has designated as the adjuster's designated home state.

3629 [~~2~~] (4) "Independent adjuster" means an insurance adjuster required to be licensed
3630 under Section 31A-26-201, who engages in insurance adjusting as a representative of one or
3631 more insurers.

3632 [~~3~~] (5) "Insurance adjusting" or "adjusting" means directing or conducting the
3633 investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an
3634 insurer, policyholder, or a claimant under an insurance policy.

3635 [~~4~~] (6) "Organization" means a person other than a natural person, and includes a sole
3636 proprietorship by which a natural person does business under an assumed name.

3637 [~~5~~] (7) "Portable electronics insurance" is as defined in Section 31A-22-1802.

3638 [~~6~~] (8) "Public adjuster" means a person required to be licensed under Section
3639 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants
3640 under insurance policies.

3641 Section 35. Section 31A-26-206 is amended to read:

3642 **31A-26-206. Continuing education requirements.**

3643 (1) Pursuant to this section, the commissioner shall by rule prescribe continuing
3644 education requirements for each class of license under Section 31A-26-204.

3645 (2) (a) The commissioner shall impose continuing education requirements in
3646 accordance with a two-year licensing period in which the licensee meets the requirements of
3647 this Subsection (2).

3648 (b) (i) Except as otherwise provided in this section, the continuing education
3649 requirements shall require:

3650 (A) that a licensee complete 24 credit hours of continuing education for every two-year
3651 licensing period;

3652 (B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses;

3653 and

3654 (C) that the licensee complete at least half of the required hours through classroom
3655 hours of insurance-related instruction.

3656 (ii) A continuing education hour completed in accordance with Subsection (2)(b)(i)
3657 may be obtained through:

3658 (A) classroom attendance;

3659 (B) home study;

3660 (C) watching a video recording;

3661 (D) experience credit; or

3662 (E) other methods provided by rule.

3663 (iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is
3664 required to complete 12 credit hours of continuing education for every two-year licensing
3665 period, with 3 of the credit hours being ethics courses.

3666 (c) A licensee may obtain continuing education hours at any time during the two-year
3667 licensing period.

3668 (d) (i) A licensee is exempt from the continuing education requirements of this section
3669 if:

3670 (A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;

3671 (B) the license does not have a continuous lapse for a period of more than one year,
3672 except for a license for which the licensee has had an exemption approved before May 11,
3673 2011;

3674 (C) the licensee requests an exemption from the department; and

3675 (D) the department approves the exemption.

3676 (ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is
3677 not required to apply again for the exemption.

3678 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3679 commissioner shall by rule:

3680 (i) publish a list of insurance professional designations whose continuing education
3681 requirements can be used to meet the requirements for continuing education under Subsection
3682 (2)(b); and

3683 (ii) authorize a professional adjuster association to:

3684 (A) offer a qualified program for a classification of license on a geographically
3685 accessible basis; and

3686 (B) collect a reasonable fee for funding and administration of a qualified program,
3687 subject to the review and approval of the commissioner.

3688 (f) (i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and
3689 administer a qualified program shall reasonably relate to the cost of administering the qualified
3690 program.

3691 (ii) Nothing in this section shall prohibit a provider of a continuing education program
3692 or course from charging a fee for attendance at a course offered for continuing education credit.

3693 (iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an
3694 association program may be less for an association member, on the basis of the member's
3695 affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

3696 (3) The continuing education requirements of this section apply only to a licensee who
3697 is an individual.

3698 (4) The continuing education requirements of this section do not apply to a member of
3699 the Utah State Bar.

3700 (5) The commissioner shall designate a course that satisfies the requirements of this
3701 section, including a course presented by an insurer.

3702 (6) A nonresident adjuster is considered to have satisfied this state's continuing
3703 education requirements if:

3704 (a) the nonresident adjuster satisfies the nonresident producer's home state's continuing
3705 education requirements for a licensed insurance adjuster; and

3706 (b) on the same basis the nonresident adjuster's home state considers satisfaction of
3707 Utah's continuing education requirements for a producer as satisfying the continuing education
3708 requirements of the home state.

3709 (7) A licensee subject to this section shall keep documentation of completing the
3710 continuing education requirements of this section for two years after the end of the two-year
3711 licensing period to which the continuing education requirement applies.

3712 Section 36. Section **31A-26-207** is amended to read:

3713 **31A-26-207. Examination requirements.**

3714 (1) The commissioner may require applicants for ~~any~~ a particular class of license

3715 under Section 31A-26-204 to pass an examination as a requirement to receiving a license. The
3716 examination shall reasonably relate to the specific license class for which it is prescribed. The
3717 examinations may be administered by the commissioner or as specified by rule.

3718 (2) The commissioner shall waive the requirement of an examination for a nonresident
3719 applicant who:

3720 (a) applies for an insurance adjuster license in this state;

3721 (b) has been licensed for the same line of authority in another state; and

3722 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
3723 applies for an insurance producer license in this state; or

3724 (ii) if the application is received within 90 days of the cancellation of the applicant's
3725 previous license:

3726 (A) the prior state certifies that at the time of cancellation, the applicant was in good
3727 standing in that state; or

3728 (B) the state's producer database records maintained by the National Association of
3729 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
3730 subsidiaries, indicates that the producer is or was licensed in good standing for the line of
3731 authority requested.

3732 (3) (a) To become a resident licensee in accordance with Sections 31A-26-202 and
3733 31A-26-203, a person licensed as an insurance producer in another state who moves to this
3734 state shall make application within 90 days of establishing legal residence in this state.

3735 (b) A person who becomes a resident licensee under Subsection (3)(a) may not be
3736 required to meet prelicensing education or examination requirements to obtain any line of
3737 authority previously held in the prior state unless:

3738 (i) the prior state would require a prior resident of this state to meet the prior state's
3739 prelicensing education or examination requirements to become a resident licensee; or

3740 (ii) the commissioner imposes the requirements by rule.

3741 (4) The requirements of this section only apply to ~~[applicants who are natural persons]~~
3742 an applicant who is a natural person.

3743 (5) The requirements of this section do not apply to ~~[members]~~;

3744 (a) a member of the Utah State Bar[-]; or

3745 (b) an applicant for the crop insurance license class who has satisfactorily completed:

3746 (i) a national crop adjuster program, as adopted by the commissioner by rule; or
3747 (ii) the loss adjustment training curriculum and competency testing required by the
3748 Federal Crop Insurance Corporation Standard Reinsurance Agreement through the Risk
3749 Management Agency of the United States Department of Agriculture.

3750 Section 37. Section 31A-26-213 is amended to read:

3751 **31A-26-213. Revocation, suspension, surrender, lapsing, limiting, or otherwise**
3752 **terminating a license -- Rulemaking for renewal or reinstatement.**

3753 (1) A license type issued under this chapter remains in force until:

3754 (a) revoked or suspended under Subsection (5);

3755 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
3756 administrative action;

3757 (c) the licensee dies or is adjudicated incompetent as defined under:

3758 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3759 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3760 Minors;

3761 (d) lapsed under Section 31A-26-214.5; or

3762 (e) voluntarily surrendered.

3763 (2) The following may be reinstated within one year after the day on which the license
3764 is no longer in force:

3765 (a) a lapsed license; or

3766 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
3767 not be reinstated after the license period in which it is voluntarily surrendered.

3768 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
3769 license, submission and acceptance of a voluntary surrender of a license does not prevent the
3770 department from pursuing additional disciplinary or other action authorized under:

3771 (a) this title; or

3772 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
3773 Administrative Rulemaking Act.

3774 (4) A license classification issued under this chapter remains in force until:

3775 (a) the qualifications pertaining to a license classification are no longer met by the
3776 licensee; or

- 3777 (b) the supporting license type:
- 3778 (i) is revoked or suspended under Subsection (5); or
- 3779 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
- 3780 administrative action.
- 3781 (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an
- 3782 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
- 3783 commissioner may:
- 3784 (i) revoke:
- 3785 (A) a license; or
- 3786 (B) a license classification;
- 3787 (ii) suspend for a specified period of 12 months or less:
- 3788 (A) a license; or
- 3789 (B) a license classification;
- 3790 (iii) limit in whole or in part:
- 3791 (A) a license; or
- 3792 (B) a license classification; or
- 3793 (iv) deny a license application.
- 3794 (b) The commissioner may take an action described in Subsection (5)(a) if the
- 3795 commissioner finds that the licensee:
- 3796 (i) is unqualified for a license or license classification under Section [31A-26-202](#),
- 3797 [31A-26-203](#), [31A-26-204](#), or [31A-26-205](#);
- 3798 (ii) has violated:
- 3799 (A) an insurance statute;
- 3800 (B) a rule that is valid under Subsection [31A-2-201\(3\)](#); or
- 3801 (C) an order that is valid under Subsection [31A-2-201\(4\)](#);
- 3802 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
- 3803 delinquency proceedings in any state;
- 3804 (iv) fails to pay a final judgment rendered against the person in this state within 60
- 3805 days after the judgment became final;
- 3806 (v) fails to meet the same good faith obligations in claims settlement that is required of
- 3807 admitted insurers;

- 3808 (vi) is affiliated with and under the same general management or interlocking
- 3809 directorate or ownership as another insurance adjuster that transacts business in this state
- 3810 without a license;
- 3811 (vii) refuses:
- 3812 (A) to be examined; or
- 3813 (B) to produce its accounts, records, and files for examination;
- 3814 (viii) has an officer who refuses to:
- 3815 (A) give information with respect to the insurance adjuster's affairs; or
- 3816 (B) perform any other legal obligation as to an examination;
- 3817 (ix) provides information in the license application that is:
- 3818 (A) incorrect;
- 3819 (B) misleading;
- 3820 (C) incomplete; or
- 3821 (D) materially untrue;
- 3822 (x) has violated an insurance law, valid rule, or valid order of another state's insurance
- 3823 department;
- 3824 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 3825 (xii) has improperly withheld, misappropriated, or converted money or properties
- 3826 received in the course of doing insurance business;
- 3827 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 3828 (A) insurance contract; or
- 3829 (B) application for insurance;
- 3830 (xiv) has been convicted of a felony;
- 3831 (xv) has admitted or been found to have committed an insurance unfair trade practice
- 3832 or fraud;
- 3833 (xvi) in the conduct of business in this state or elsewhere has:
- 3834 (A) used fraudulent, coercive, or dishonest practices; or
- 3835 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 3836 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in
- 3837 any other state, province, district, or territory;
- 3838 (xviii) has forged another's name to:

- 3839 (A) an application for insurance; or
3840 (B) a document related to an insurance transaction;
3841 (xix) has improperly used notes or any other reference material to complete an
3842 examination for an insurance license;
3843 (xx) has knowingly accepted insurance business from an individual who is not
3844 licensed;
3845 (xxi) has failed to comply with an administrative or court order imposing a child
3846 support obligation;
3847 (xxii) has failed to:
3848 (A) pay state income tax; or
3849 (B) comply with an administrative or court order directing payment of state income
3850 tax;
3851 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and
3852 Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 [~~and 1034~~] and therefore under 18 U.S.C.
3853 Sec. 1033 is prohibited from engaging in the business of insurance; or
3854 (xxiv) has engaged in methods and practices in the conduct of business that endanger
3855 the legitimate interests of customers and the public.
3856 (c) For purposes of this section, if a license is held by an agency, both the agency itself
3857 and any individual designated under the license are considered to be the holders of the license.
3858 (d) If an individual designated under the agency license commits an act or fails to
3859 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
3860 the commissioner may suspend, revoke, or limit the license of:
3861 (i) the individual;
3862 (ii) the agency, if the agency:
3863 (A) is reckless or negligent in its supervision of the individual; or
3864 (B) knowingly participated in the act or failure to act that is the ground for suspending,
3865 revoking, or limiting the license; or
3866 (iii) (A) the individual; and
3867 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
3868 (6) A licensee under this chapter is subject to the penalties for conducting an insurance
3869 business without a license if:

- 3870 (a) the licensee's license is:
- 3871 (i) revoked;
- 3872 (ii) suspended;
- 3873 (iii) limited;
- 3874 (iv) surrendered in lieu of administrative action;
- 3875 (v) lapsed; or
- 3876 (vi) voluntarily surrendered; and
- 3877 (b) the licensee:
- 3878 (i) continues to act as a licensee; or
- 3879 (ii) violates the terms of the license limitation.
- 3880 (7) A licensee under this chapter shall immediately report to the commissioner:
- 3881 (a) a revocation, suspension, or limitation of the person's license in any other state, the
- 3882 District of Columbia, or a territory of the United States;
- 3883 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
- 3884 the District of Columbia, or a territory of the United States; or
- 3885 (c) a judgment or injunction entered against that person on the basis of conduct
- 3886 involving:
- 3887 (i) fraud;
- 3888 (ii) deceit;
- 3889 (iii) misrepresentation; or
- 3890 (iv) a violation of an insurance law or rule.
- 3891 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
- 3892 license in lieu of administrative action may specify a time not to exceed five years within
- 3893 which the former licensee may not apply for a new license.
- 3894 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the
- 3895 former licensee may not apply for a new license for five years without the express approval of
- 3896 the commissioner.
- 3897 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
- 3898 a license issued under this part if so ordered by a court.
- 3899 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
- 3900 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3901 Section 38. Section **31A-26-214** is amended to read:

3902 **31A-26-214. Probation -- Grounds for revocation.**

3903 (1) The commissioner may place a licensee on probation for a period not to exceed 24
3904 months as follows:

3905 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
3906 Procedures Act, for any circumstances that would justify a suspension under Section
3907 **31A-26-213**; or

3908 (b) at the issuance of a new license:

3909 (i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or

3910 (ii) with a response to a background information question on any new license
3911 application indicating that:

3912 (A) the person has been convicted of a crime, that is listed by rule made in accordance
3913 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for
3914 probation;

3915 (B) the person is currently charged with a crime, that is listed by rule made in
3916 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
3917 grounds for probation regardless of whether adjudication was withheld;

3918 (C) the person has been involved in an administrative proceeding regarding any
3919 professional or occupational license; or

3920 (D) any business in which the person is or was an owner, partner, officer, or director
3921 has been involved in an administrative proceeding regarding any professional or occupational
3922 license.

3923 (2) The commissioner may put a licensee on probation for a specified period no longer
3924 than 24 months if the licensee has admitted to violations under 18 U.S.C. [~~Sections~~] Sec. 1033
3925 [~~and 1034~~].

3926 (3) A probation order under this section shall state the conditions for retention of the
3927 license, which shall be reasonable.

3928 (4) A violation of the probation is grounds for revocation pursuant to any proceeding
3929 authorized under Title 63G, Chapter 4, Administrative Procedures Act.

3930 Section 39. Section **31A-26-214.5** is amended to read:

3931 **31A-26-214.5. License lapse and voluntary surrender.**

3932 (1) (a) A license issued under this chapter shall lapse if the licensee fails to:
3933 (i) pay when due a fee under Section 31A-3-103;
3934 (ii) complete continuing education requirements under Section 31A-26-206 before
3935 submitting the license renewal application;
3936 (iii) submit a completed renewal application as required by Section 31A-26-202;
3937 (iv) submit additional documentation required to complete the licensing process as
3938 related to a specific license type or license classification; or
3939 (v) maintain an active license in [~~a resident~~] the licensee's home state if the licensee is
3940 a nonresident licensee.

3941 (b) (i) A licensee whose license lapses due to the following may request an action
3942 described in Subsection (1)(b)(ii):

3943 (A) military service;
3944 (B) voluntary service for a period of time designated by the person for whom the
3945 licensee provides voluntary service; or
3946 (C) some other extenuating circumstances, such as long-term medical disability.

3947 (ii) A licensee described in Subsection (1)(b)(i) may request:

3948 (A) reinstatement of the license no later than one year after the day on which the
3949 license lapses; and
3950 (B) waiver of any of the following imposed for failure to comply with renewal
3951 procedures:

3952 (I) an examination requirement;
3953 (II) reinstatement fees set under Section 31A-3-103;
3954 (III) continuing education requirements; or
3955 (IV) other sanction imposed for failure to comply with renewal procedures.

3956 (2) If a license issued under this chapter is voluntarily surrendered, the license may be
3957 reinstated:

3958 (a) during the license period in which it is voluntarily surrendered; and
3959 (b) no later than one year after the day on which the license is voluntarily surrendered.

3960 Section 40. Section 31A-27a-102 is amended to read:

3961 **31A-27a-102. Definitions.**
3962 As used in this chapter:

3963 (1) "Admitted assets" is as defined by and is measured in accordance with the National
3964 Association of Insurance Commissioner's Statements of Statutory Accounting Principles, as
3965 incorporated in this state by rules made by the department in accordance with Title 63G,
3966 Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection
3967 31A-4-113(1)(b)(ii).

3968 (2) "Affected guaranty association" means a guaranty association that is or may
3969 become liable for payment of a covered claim.

3970 (3) "Affiliate" is as defined in Section 31A-1-301.

3971 (4) Notwithstanding Section 31A-1-301, "alien insurer" means an insurer incorporated
3972 or organized under the laws of a jurisdiction that is not a state.

3973 (5) Notwithstanding Section 31A-1-301, "claimant" or "creditor" means a person
3974 having a claim against an insurer whether the claim is:

3975 (a) matured or not matured;

3976 (b) liquidated or unliquidated;

3977 (c) secured or unsecured;

3978 (d) absolute; or

3979 (e) fixed or contingent.

3980 (6) "Commissioner" is as defined in Section 31A-1-301.

3981 (7) "Commodity contract" means:

3982 (a) a contract for the purchase or sale of a commodity for future delivery on, or subject
3983 to the rules of:

3984 (i) a board of trade or contract market under the Commodity Exchange Act, 7 U.S.C.
3985 Sec. 1 et seq.; or

3986 (ii) a board of trade outside the United States;

3987 (b) an agreement that is:

3988 (i) subject to regulation under Section 19 of the Commodity Exchange Act, 7 U.S.C.
3989 Sec. 1 et seq.; and

3990 (ii) commonly known to the commodities trade as:

3991 (A) a margin account;

3992 (B) a margin contract;

3993 (C) a leverage account; or

- 3994 (D) a leverage contract;
- 3995 (c) an agreement or transaction that is:
- 3996 (i) subject to regulation under Section 4c(b) of the Commodity Exchange Act, 7 U.S.C.
- 3997 Sec. 1 et seq.; and
- 3998 (ii) commonly known to the commodities trade as a commodity option;
- 3999 (d) a combination of the agreements or transactions referred to in this Subsection (7);
- 4000 or
- 4001 (e) an option to enter into an agreement or transaction referred to in this Subsection (7).
- 4002 (8) "Control" is as defined in Section [31A-1-301](#).
- 4003 (9) "Delinquency proceeding" means a:
- 4004 (a) proceeding instituted against an insurer for the purpose of rehabilitating or
- 4005 liquidating the insurer; and
- 4006 (b) summary proceeding under Section [31A-27a-201](#).
- 4007 (10) "Department" is as defined in Section [31A-1-301](#) unless the context requires
- 4008 otherwise.
- 4009 (11) "Doing business," "doing insurance business," and "business of insurance"
- 4010 includes any of the following acts, whether effected by mail, electronic means, or otherwise:
- 4011 (a) issuing or delivering a contract, certificate, or binder relating to insurance or
- 4012 annuities:
- 4013 (i) to a person who is resident in this state; or
- 4014 (ii) covering a risk located in this state;
- 4015 (b) soliciting an application for the contract, certificate, or binder described in
- 4016 Subsection (11)(a);
- 4017 (c) negotiating preliminary to the execution of the contract, certificate, or binder
- 4018 described in Subsection (11)(a);
- 4019 (d) collecting premiums, membership fees, assessments, or other consideration for the
- 4020 contract, certificate, or binder described in Subsection (11)(a);
- 4021 (e) transacting matters:
- 4022 (i) subsequent to execution of the contract, certificate, or binder described in
- 4023 Subsection (11)(a); and
- 4024 (ii) arising out of the contract, certificate, or binder described in Subsection (11)(a);

4025 (f) operating as an insurer under a license or certificate of authority issued by the
4026 department; or

4027 (g) engaging in an act identified in Chapter 15, Unauthorized Insurers, Surplus Lines,
4028 and Risk Retention Groups.

4029 (12) Notwithstanding Section 31A-1-301, "domiciliary state" means the state in which
4030 an insurer is incorporated or organized, except that "domiciliary state" means:

4031 (a) in the case of an alien insurer, its state of entry; or

4032 (b) in the case of a risk retention group, the state in which the risk retention group is
4033 chartered as contemplated in the Liability Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.

4034 (13) "Estate" has the same meaning as "property of the insurer" as defined in
4035 Subsection (30).

4036 (14) "Fair consideration" is given for property or an obligation:

4037 (a) when in exchange for the property or obligation, as a fair equivalent for it, and in
4038 good faith:

4039 (i) property is conveyed;

4040 (ii) services are rendered;

4041 (iii) an obligation is incurred; or

4042 (iv) an antecedent debt is satisfied; or

4043 (b) when the property or obligation is received in good faith to secure a present
4044 advance or an antecedent debt in amount not disproportionately small compared to the value of
4045 the property or obligation obtained.

4046 (15) Notwithstanding Section 31A-1-301, "foreign insurer" means an insurer domiciled
4047 in another state.

4048 (16) "Formal delinquency proceeding" means a rehabilitation or liquidation
4049 proceeding.

4050 (17) "Forward contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C.
4051 Sec. 1821(e)(8)(D).

4052 (18) (a) "General assets" include all property of the estate that is not:

4053 (i) subject to a properly perfected secured claim;

4054 (ii) subject to a valid and existing express trust for the security or benefit of a specified
4055 person or class of person; or

4056 (iii) required by the insurance laws of this state or any other state to be held for the
4057 benefit of a specified person or class of person.

4058 (b) "General assets" include ~~all~~ the property of the estate or its proceeds in excess of
4059 the amount necessary to discharge a claim described in Subsection (18)(a).

4060 (19) "Good faith" means honesty in fact and intention, and in regard to Part 5, Asset
4061 Recovery, also requires the absence of:

4062 (a) information that would lead a reasonable person in the same position to know that
4063 the insurer is financially impaired or insolvent; and

4064 (b) knowledge regarding the imminence or pendency of a delinquency proceeding
4065 against the insurer.

4066 (20) "Guaranty association" means:

4067 (a) a mechanism mandated by Chapter 28, Guaranty Associations; or

4068 (b) a similar mechanism in another state that is created for the payment of claims or
4069 continuation of policy obligations of a financially impaired or insolvent insurer.

4070 (21) "Impaired" means that an insurer:

4071 (a) does not have admitted assets at least equal to the sum of:

4072 (i) all its liabilities; and

4073 (ii) the minimum surplus required to be maintained by Section 31A-5-211 or
4074 31A-8-209; or

4075 (b) has a total adjusted capital that is less than its authorized control level RBC, as
4076 defined in Section 31A-17-601.

4077 (22) "Insolvency" or "insolvent" means that an insurer:

4078 (a) is unable to pay its obligations when they are due;

4079 (b) does not have admitted assets at least equal to all of its liabilities; or

4080 (c) has a total adjusted capital that is less than its mandatory control level RBC, as
4081 defined in Section 31A-17-601.

4082 (23) Notwithstanding Section 31A-1-301, "insurer" means a person who:

4083 (a) is doing, has done, purports to do, or is licensed to do the business of insurance;

4084 (b) is or has been subject to the authority of, or to rehabilitation, liquidation,
4085 reorganization, supervision, or conservation by an insurance commissioner; or

4086 (c) is included under Section 31A-27a-104.

4087 (24) "Liabilities" is as defined by and is measured in accordance with the National
4088 Association of Insurance Commissioner's Statements of Statutory Accounting Principles, as
4089 incorporated in this state by rules made by the department in accordance with Title 63G,
4090 Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection
4091 [31A-4-113\(1\)\(b\)\(ii\)](#).

4092 (25) (a) Subject to Subsection (21)(b), "netting agreement" means:

4093 (i) a contract or agreement that:

4094 (A) documents one or more transactions between the parties to the agreement for or
4095 involving one or more qualified financial contracts; and

4096 (B) provides for the netting, liquidation, setoff, termination, acceleration, or close out
4097 under or in connection with:

4098 (I) one or more qualified financial contracts; or

4099 (II) present or future payment or delivery obligations or payment or delivery
4100 entitlements under the agreement, including liquidation or close-out values relating to the
4101 obligations or entitlements, among the parties to the netting agreement;

4102 (ii) a master agreement or bridge agreement for one or more master agreements
4103 described in Subsection (25)(a)(i); or

4104 (iii) any of the following related to a contract or agreement described in Subsection
4105 (25)(a)(i) or (ii):

4106 (A) a security agreement;

4107 (B) a security arrangement;

4108 (C) other credit enhancement or guarantee; or

4109 (D) a reimbursement obligation.

4110 (b) If a contract or agreement described in Subsection (25)(a)(i) or (ii) relates to an
4111 agreement or transaction that is not a qualified financial contract, the contract or agreement
4112 described in Subsection (25)(a)(i) or (ii) is considered a netting agreement only with respect to
4113 an agreement or transaction that is a qualified financial contract.

4114 (c) "Netting agreement" includes:

4115 (i) a term or condition incorporated by reference in the contract or agreement described
4116 in Subsection (25)(a); or

4117 (ii) a master agreement described in Subsection (25)(a).

4118 (d) A master agreement described in Subsection (25)(a), together with all schedules,
4119 confirmations, definitions, and addenda to that master agreement and transactions under any of
4120 the items described in this Subsection (25)(d), are treated as one netting agreement.

4121 (26) (a) "New value" means:

4122 (i) money;

4123 (ii) money's worth in goods, services, or new credit; or

4124 (iii) release by a transferee of property previously transferred to the transferee in a

4125 transaction that is neither void nor voidable by the insurer or the receiver under [any]

4126 applicable law, including proceeds of the property.

4127 (b) "New value" does not include an obligation substituted for an existing obligation.

4128 (27) "Party in interest" means:

4129 (a) the commissioner;

4130 (b) a nondomiciliary commissioner in whose state the insurer has outstanding claims
4131 liabilities;

4132 (c) an affected guaranty association; and

4133 (d) the following parties if the party files a request with the receivership court for

4134 inclusion as a party in interest and to be on the service list:

4135 (i) an insurer that ceded to or assumed business from the insurer;

4136 (ii) a policyholder;

4137 (iii) a third party claimant;

4138 (iv) a creditor;

4139 (v) a 10% or greater equity security holder in the insolvent insurer; and

4140 (vi) a person, including an indenture trustee, with a financial or regulatory interest in

4141 the delinquency proceeding.

4142 (28) (a) Notwithstanding Section 31A-1-301, "policy" means, notwithstanding what it
4143 is called:

4144 (i) a written contract of insurance;

4145 (ii) a written agreement for or affecting insurance; or

4146 (iii) a certificate of a written contract or agreement described in this Subsection (28)(a).

4147 (b) "Policy" includes all clauses, riders, endorsements, and papers that are a part of a
4148 policy.

4149 (c) "Policy" does not include a contract of reinsurance.

4150 (29) "Preference" means a transfer of property of an insurer to or for the benefit of a
4151 creditor:

4152 (a) for or on account of an antecedent debt, made or allowed by the insurer within one
4153 year before the day on which a successful petition for rehabilitation or liquidation is filed under
4154 this chapter;

4155 (b) the effect of which transfer may enable the creditor to obtain a greater percentage of
4156 the creditor's debt than another creditor of the same class would receive; and

4157 (c) if a liquidation order is entered while the insurer is already subject to a
4158 rehabilitation order and the transfer otherwise qualifies, that is made or allowed within the
4159 shorter of:

4160 (i) one year before the day on which a successful petition for rehabilitation is filed; or

4161 (ii) two years before the day on which a successful petition for liquidation is filed.

4162 (30) "Property of the insurer" or "property of the estate" includes:

4163 (a) a right, title, or interest of the insurer in property:

4164 (i) whether:

4165 (A) legal or equitable;

4166 (B) tangible or intangible; or

4167 (C) choate or inchoate; and

4168 (ii) including choses in action, contract rights, and any other interest recognized under
4169 the laws of this state;

4170 (b) entitlements that exist before the entry of an order of rehabilitation or liquidation;

4171 (c) entitlements that may arise by operation of this chapter or other provisions of law
4172 allowing the receiver to avoid prior transfers or assert other rights; and

4173 (d) (i) records or data that is otherwise the property of the insurer; and

4174 (ii) records or data similar to those described in Subsection (30)(d)(i) that are within
4175 the possession, custody, or control of a managing general agent, a third party administrator, a
4176 management company, a data processing company, an accountant, an attorney, an affiliate, or
4177 other person.

4178 (31) Subject to Subsection [31A-27a-611](#)(10), "qualified financial contract" means any
4179 of the following:

- 4180 (a) a commodity contract;
- 4181 (b) a forward contract;
- 4182 (c) a repurchase agreement;
- 4183 (d) a securities contract;
- 4184 (e) a swap agreement; or
- 4185 (f) [any] a similar agreement that the commissioner determines by rule or order to be a
- 4186 qualified financial contract for purposes of this chapter.

4187 (32) As the context requires, "receiver" means the commissioner or the commissioner's

4188 designee, including a rehabilitator, liquidator, or ancillary receiver.

4189 (33) As the context requires, "receivership" means a rehabilitation, liquidation, or

4190 ancillary receivership.

4191 (34) Unless the context requires otherwise, "receivership court" refers to the court in

4192 which a delinquency proceeding is pending.

4193 (35) "Reciprocal state" means [any] a state other than this state that:

- 4194 (a) enforces a law substantially similar to this chapter;
- 4195 (b) requires the commissioner to be the receiver of a delinquent insurer; and
- 4196 (c) has laws for the avoidance of fraudulent conveyances and preferential transfers by
- 4197 the receiver of a delinquent insurer.

4198 (36) "Record," when used as a noun, means [any] information or data, in whatever

4199 form maintained, including:

- 4200 (a) a book;
- 4201 (b) a document;
- 4202 (c) a paper;
- 4203 (d) a file;
- 4204 (e) an application file;
- 4205 (f) a policyholder list;
- 4206 (g) policy information;
- 4207 (h) a claim or claim file;
- 4208 (i) an account;
- 4209 (j) a voucher;
- 4210 (k) a litigation file;

4211 (l) a premium record;

4212 (m) a rate book;

4213 (n) an underwriting manual;

4214 (o) a personnel record;

4215 (p) a financial record; or

4216 (q) other material.

4217 (37) "Reinsurance" means a transaction or contract under which an assuming insurer
4218 agrees to indemnify a ceding insurer against all, or a part, of ~~any~~ a loss that the ceding insurer
4219 may sustain under the one or more policies that the ceding insurer issues or will issue.

4220 (38) "Repurchase agreement" is as defined in the Federal Deposit Insurance Act, 12
4221 U.S.C. Sec. 1821(e)(8)(D).

4222 (39) (a) "Secured claim" means, subject to Subsection (39)(b):

4223 (i) a claim secured by an asset that is not a general asset; or

4224 (ii) the right to set off as provided in Section [31A-27a-510](#).

4225 (b) "Secured claim" does not include:

4226 (i) a special deposit claim;

4227 (ii) a claim based on mere possession; or

4228 (iii) a claim arising from a constructive or resulting trust.

4229 (40) "Securities contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C.
4230 Sec. 1821(e)(8)(D).

4231 (41) "Special deposit" means a deposit established pursuant to statute for the security
4232 or benefit of a limited class or classes of persons.

4233 (42) (a) Subject to Subsection (42)(b), "special deposit claim" means a claim secured
4234 by a special deposit.

4235 (b) "Special deposit claim" does not include a claim against the general assets of the
4236 insurer.

4237 (43) "State" means a state, district, or territory of the United States.

4238 (44) "Subsidiary" is as defined in Section [31A-1-301](#).

4239 (45) "Swap agreement" is as defined in the Federal Deposit Insurance Act, 12 U.S.C.
4240 Sec. 1821(e)(8)(D).

4241 (46) (a) "Transfer" includes the sale and every other and different mode of disposing of

4242 or parting with property or with an interest in property, whether:

4243 (i) directly or indirectly;

4244 (ii) absolutely or conditionally;

4245 (iii) voluntarily or involuntarily; or

4246 (iv) by or without judicial proceedings.

4247 (b) An interest in property includes:

4248 (i) a set off;

4249 (ii) having possession of the property; or

4250 (iii) fixing a lien on the property or on an interest in the property.

4251 (c) The retention of a security title in property delivered to an insurer and foreclosure

4252 of the insurer's equity of redemption is considered a transfer suffered by the insurer.

4253 (47) Notwithstanding Section 31A-1-301, "unauthorized insurer" means an insurer

4254 transacting the business of insurance in this state that has not received a certificate of authority

4255 from this state, or some other type of authority that allows for the transaction of the business of

4256 insurance in this state.

4257 Section 41. Section 31A-27a-107 is amended to read:

4258 **31A-27a-107. Notice and hearing on matters submitted by the receiver for**
4259 **receivership court approval.**

4260 (1) (a) Upon written request to the receiver, a person shall be placed on the service list

4261 to receive notice of matters filed by the receiver. The person shall include in a written request

4262 under this Subsection (1)(a) the person's address, facsimile number, or electronic mail address.

4263 (b) It is the responsibility of the person requesting notice to:

4264 (i) inform the receiver in writing of any changes in the person's address, facsimile
4265 number, and electronic mail address; or

4266 (ii) request that the person's name be deleted from the service list.

4267 (c) (i) The receiver may serve on a person on the service list a request to confirm

4268 continuation on the service list by returning a form.

4269 (ii) The request to confirm continuation may be served periodically but not more

4270 frequently than every 12 months.

4271 (iii) A person who fails to return the form described in this Subsection (1)(c) may be

4272 removed from the service list.

4273 (d) Inclusion on the service list does not confer standing in the delinquency proceeding
4274 to raise, appear, or be heard on any issue.

4275 (e) The receiver shall:

4276 (i) file a copy of the service list with the receivership court; and

4277 (ii) periodically provide to the receivership court notice of changes to the service list.

4278 (f) Notice may be provided by first-class mail postage paid, electronic mail, or
4279 facsimile transmission, at the receiver's discretion.

4280 (2) Except as otherwise provided by this chapter, notice and hearing of any matter
4281 submitted by the receiver to the receivership court for approval under this chapter shall be
4282 conducted in accordance with this Subsection (2).

4283 (a) The receiver:

4284 (i) shall file a motion:

4285 (A) explaining the proposed action; and

4286 (B) the basis for the proposed action; and

4287 (ii) may include any evidence in support of the motion.

4288 (b) If a document, material, or other information supporting the motion is confidential,
4289 the document, material, or other information may be submitted to the receivership court under
4290 seal for in camera inspection.

4291 (c) (i) The receiver shall provide notice and a copy of the motion to:

4292 (A) all persons on the service list; and

4293 (B) any other person as may be required by the receivership court.

4294 (ii) Notice may be provided by first-class mail postage paid, electronic mail, or
4295 facsimile transmission, at the receiver's discretion.

4296 (iii) For purposes of this section, notice is considered to be given on the day on which
4297 it is deposited with the United States Postmaster or transmitted, as applicable, to the
4298 last-known address as shown on the service list.

4299 (d) (i) A party in interest objecting to the motion shall:

4300 (A) file an objection specifying the grounds for the objection within:

4301 (I) 10 days of the day on which the notice of the filing of the motion is sent; or

4302 (II) such other time as the receivership court may specify; and

4303 (B) serve copies on:

4304 (I) the receiver; and
4305 (II) any other person served with the motion within the time period described in this
4306 Subsection (2)(d)(i).

4307 (ii) In accordance with the Utah Rules of Civil Procedure, days may be added to the
4308 time for filing an objection if the notice of the motion is sent only by way of United States
4309 mail.

4310 (iii) An objecting party has the burden of showing why the receivership court should
4311 not authorize the proposed action.

4312 (e) (i) If no objection to the motion is timely filed:

4313 (A) the receivership court may:

4314 (I) enter an order approving the motion without a hearing; or

4315 (II) hold a hearing to determine if the receiver's motion should be approved; and

4316 (B) the receiver may request that the receivership court enter an order or hold a hearing
4317 on an expedited basis.

4318 (ii) (A) If an objection is timely filed, the receivership court may hold a hearing.

4319 (B) If the receivership court approves the motion and, upon a motion by the receiver,
4320 determines that the objection is frivolous or filed merely for delay or for other improper
4321 purpose, the receivership court may order the objecting party to pay the receiver's reasonable
4322 costs and fees of defending against the objection.

4323 Section 42. Section **31A-27a-201** is amended to read:

4324 **31A-27a-201. Receivership court's seizure order.**

4325 (1) The commissioner may file in the Third District Court for Salt Lake County a
4326 petition:

4327 (a) with respect to:

4328 (i) an insurer domiciled in this state;

4329 (ii) an unauthorized insurer; or

4330 (iii) pursuant to Section [31A-27a-901](#), a foreign insurer;

4331 (b) alleging that:

4332 (i) there exists grounds that would justify a court order for a formal delinquency
4333 proceeding against the insurer under this chapter; and

4334 (ii) the interests of policyholders, creditors, or the public will be endangered by delay;

4335 and

4336 (c) setting forth the contents of a seizure order considered necessary by the
4337 commissioner.

4338 (2) (a) Upon a filing under Subsection (1), the receivership court may issue the
4339 requested seizure order:

4340 (i) immediately, ex parte, and without notice or hearing;

4341 (ii) that directs the commissioner to take possession and control of:

4342 (A) all or a part of the property, accounts, and records of an insurer; and

4343 (B) the premises occupied by the insurer for transaction of the insurer's business; and

4344 (iii) that until further order of the receivership court, enjoins the insurer and its officers,
4345 managers, agents, and employees from disposition of its property and from the transaction of
4346 its business except with the written consent of the commissioner.

4347 (b) ~~[Any]~~ A person having possession or control of and refusing to deliver any of the
4348 records or assets of a person against whom a seizure order is issued under this Subsection (2) is
4349 guilty of a class B misdemeanor.

4350 (3) (a) A petition that requests injunctive relief:

4351 (i) shall be verified by the commissioner or the commissioner's designee; and

4352 (ii) is not required to plead or prove irreparable harm or inadequate remedy at law.

4353 (b) The commissioner shall provide only the notice that the receivership court may
4354 require.

4355 (4) (a) The receivership court shall specify in the seizure order the duration of the
4356 seizure, which shall be the time the receivership court considers necessary for the
4357 commissioner to ascertain the condition of the insurer.

4358 (b) The receivership court may from time to time:

4359 (i) hold a hearing that the receivership court considers desirable:

4360 (A) (I) on motion of the commissioner;

4361 (II) on motion of the insurer; or

4362 (III) on its own motion; and

4363 (B) after the notice the receivership court considers appropriate; and

4364 (ii) extend, shorten, or modify the terms of the seizure order.

4365 (c) The receivership court shall vacate the seizure order if the commissioner fails to

4366 commence a formal proceeding under this chapter after having had a reasonable opportunity to
4367 commence a formal proceeding under this chapter.

4368 (d) An order of the receivership court pursuant to a formal proceeding under this
4369 chapter vacates the seizure order.

4370 (5) Entry of a seizure order under this section does not constitute a breach or an
4371 anticipatory breach of [any] a contract of the insurer.

4372 (6) (a) An insurer subject to an ex parte seizure order under this section may petition
4373 the receivership court at any time after the issuance of a seizure order for a hearing and review
4374 of the basis for the seizure order.

4375 (b) The receivership court shall hold the hearing and review requested under this
4376 Subsection (6) not more than 15 days after the day on which the request is received or as soon
4377 thereafter as the court may allow.

4378 (c) A hearing under this Subsection (6):

4379 (i) may be held privately in chambers; and

4380 (ii) shall be held privately in chambers if the insurer proceeded against requests that it
4381 be private.

4382 (7) (a) If, at any time after the issuance of a seizure order, it appears to the receivership
4383 court that a person whose interest is or will be substantially affected by the seizure order did
4384 not appear at the hearing and has not been served, the receivership court may order that notice
4385 be given to the person.

4386 (b) An order under this Subsection (7) that notice be given may not stay the effect of
4387 [any] a seizure order previously issued by the receivership court.

4388 (8) Whenever the commissioner makes a seizure as provided in Subsection (2), on the
4389 demand of the commissioner, it shall be the duty of the sheriff of a county of this state, and of
4390 the police department of a municipality in the state to furnish the commissioner with necessary
4391 deputies or officers to assist the commissioner in making and enforcing the seizure order.

4392 (9) The commissioner may appoint a receiver under this section. The insurer shall pay
4393 the costs and expenses of the receiver appointed.

4394 Section 43. Section **31A-27a-701** is amended to read:

4395 **31A-27a-701. Priority of distribution.**

4396 (1) (a) The priority of payment of distributions on unsecured claims shall be in

4397 accordance with the order in which each class of claim is set forth in this section except as
4398 provided in Section 31A-27a-702.

4399 (b) All claims in each class shall be paid in full or adequate funds retained for the
4400 claim's payment before a member of the next class receives payment.

4401 (c) All claims within a class shall be paid substantially the same percentage.

4402 (d) Except as provided in Subsections (2)(a)(i)(E), (2)(k), and (2)(m), subclasses may
4403 not be established within a class.

4404 (e) A claim by a shareholder, policyholder, or other creditor may not be permitted to
4405 circumvent the priority classes through the use of equitable remedies.

4406 (2) The order of distribution of claims shall be as follows:

4407 (a) a Class 1 claim, which:

4408 (i) is a cost or expense of administration expressly approved or ratified by the
4409 liquidator, including the following:

4410 (A) the actual and necessary costs of preserving or recovering the property of the
4411 insurer;

4412 (B) reasonable compensation for all services rendered on behalf of the administrative
4413 supervisor or receiver;

4414 (C) a necessary filing fee;

4415 (D) the fees and mileage payable to a witness;

4416 (E) an unsecured loan obtained by the receiver, which:

4417 (I) unless its terms otherwise provide, has priority over all other costs of
4418 administration; and

4419 (II) absent agreement to the contrary, shares pro rata with all other claims described in
4420 this Subsection (2)(a)(i)(E); and

4421 (F) an expense approved by the rehabilitator of the insurer, if any, incurred in the
4422 course of the rehabilitation that is unpaid at the time of the entry of the order of liquidation; and

4423 (ii) except as expressly approved by the receiver, excludes any expense arising from a
4424 duty to indemnify a director, officer, or employee of the insurer which expense, if allowed, is a
4425 Class 7 claim;

4426 (b) a Class 2 claim, which:

4427 (i) is a reasonable expense of a guaranty association, including overhead, salaries, or

4428 other general administrative expenses allocable to the receivership such as:

4429 (A) an administrative or claims handling expense;

4430 (B) an expense in connection with arrangements for ongoing coverage; and

4431 (C) in the case of a property and casualty guaranty association, a loss adjustment

4432 expense, including:

4433 (I) an adjusting or other expense; and

4434 (II) a defense or cost containment expense; and

4435 (ii) excludes an expense incurred in the performance of duties under Section

4436 [31A-28-112](#) or similar duties under the statute governing a similar organization in another

4437 state;

4438 (c) a Class 3 claim, which:

4439 (i) is:

4440 (A) a claim under a policy of insurance including a third party claim;

4441 (B) a claim under an annuity contract or funding agreement;

4442 (C) a claim under a nonassessable policy for unearned premium;

4443 (D) a claim of an obligee and, subject to the discretion of the receiver, a completion

4444 contractor under a surety bond or surety undertaking, except for:

4445 (I) a bail bond;

4446 (II) a mortgage guaranty;

4447 (III) a financial guaranty; or

4448 (IV) other form of insurance offering protection against investment risk or warranties;

4449 (E) a claim by a principal under a surety bond or surety undertaking for wrongful

4450 dissipation of collateral by the insurer or its agents;

4451 (F) an indemnity payment on:

4452 (I) a covered claim; or

4453 [~~(H)~~ ~~unearned premium; or~~]

4454 [~~(H)~~] (II) a payment for the continuation of coverage made by an entity responsible for

4455 the payment of a claim or continuation of coverage of an insolvent health maintenance

4456 organization;

4457 (G) a claim for unearned premium;

4458 [~~(G)~~] (H) a claim incurred during the extension of coverage provided for in Sections

4459 31A-27a-402 and 31A-27a-403; or

4460 ~~(H)~~ (I) all other claims incurred in fulfilling the statutory obligations of a guaranty
4461 association not included in Class 2, including:

4462 (I) an indemnity payment on covered claims; and

4463 (II) in the case of a life and health guaranty association, a claim:

4464 (Aa) as a creditor of the impaired or insolvent insurer for a payment of and liabilities
4465 incurred on behalf of a covered claim or covered obligation of the insurer; and

4466 (Bb) for the funds needed to reinsure the obligations described under this Subsection

4467 (2)(c)(i)(H)(II) with a solvent insurer; and

4468 (ii) notwithstanding any other provision of this chapter, excludes the following which
4469 shall be paid under Class 7, except as provided in this section:

4470 (A) an obligation of the insolvent insurer arising out of a reinsurance contract;

4471 (B) an obligation that is incurred pursuant to an occurrence policy or reported pursuant
4472 to a claims made policy after:

4473 (I) the expiration date of the policy;

4474 (II) the policy is replaced by the insured;

4475 (III) the policy is canceled at the insured's request; or

4476 (IV) the policy is canceled as provided in this chapter;

4477 (C) an obligation to an insurer, insurance pool, or underwriting association and the
4478 insurer's, insurance pool's, or underwriting association's claim for contribution, indemnity, or
4479 subrogation, equitable or otherwise, except for direct claims under a policy where the insurer is
4480 the named insured;

4481 (D) an amount accrued as punitive or exemplary damages unless expressly covered
4482 under the terms of the policy, which shall be paid as a claim in Class 9;

4483 (E) a tort claim of any kind against the insurer;

4484 (F) a claim against the insurer for bad faith or wrongful settlement practices; and

4485 (G) a claim of a guaranty association for assessments not paid by the insurer, which
4486 claims shall be paid as claims in Class 7; and

4487 (iii) notwithstanding Subsection (2)(c)(ii)(B), does not exclude an unearned premium
4488 claim on a policy, other than a reinsurance agreement;

4489 (d) a Class 4 claim, which is a claim under a policy for mortgage guaranty, financial

- 4490 guaranty, or other forms of insurance offering protection against investment risk or warranties;
- 4491 (e) a Class 5 claim, which is a claim of the federal government not included in Class 3
- 4492 or 4;
- 4493 (f) a Class 6 claim, which is a debt due an employee for services or benefits:
- 4494 (i) to the extent that the expense:
- 4495 (A) does not exceed the lesser of:
- 4496 (I) \$5,000; or
- 4497 (II) two months' salary; and
- 4498 (B) represents payment for services performed within one year before the day on which
- 4499 the initial order of receivership is issued; and
- 4500 (ii) which priority is in lieu of any other similar priority that may be authorized by law
- 4501 as to wages or compensation of employees;
- 4502 (g) a Class 7 claim, which is a claim of an unsecured creditor not included in Classes 1
- 4503 through 6, including:
- 4504 (i) a claim under a reinsurance contract;
- 4505 (ii) a claim of a guaranty association for an assessment not paid by the insurer; and
- 4506 (iii) other claims excluded from Class 3 or 4, unless otherwise assigned to Classes 8
- 4507 through 13;
- 4508 (h) subject to Subsection (3), a Class 8 claim, which is:
- 4509 (i) a claim of a state or local government, except a claim specifically classified
- 4510 elsewhere in this section; or
- 4511 (ii) a claim for services rendered and expenses incurred in opposing a formal
- 4512 delinquency proceeding;
- 4513 (i) a Class 9 claim, which is a claim for penalties, punitive damages, or forfeitures,
- 4514 unless expressly covered under the terms of a policy of insurance;
- 4515 (j) a Class 10 claim, which is, except as provided in Subsections [31A-27a-601\(2\)](#) and
- 4516 [31A-27a-601\(3\)](#), a late filed claim that would otherwise be classified in Classes 3 through 9;
- 4517 (k) subject to Subsection (4), a Class 11 claim, which is:
- 4518 (i) a surplus note;
- 4519 (ii) a capital note;
- 4520 (iii) a contribution note;

- 4521 (iv) a similar obligation;
- 4522 (v) a premium refund on an assessable policy; or
- 4523 (vi) any other claim specifically assigned to this class;
- 4524 (l) a Class 12 claim, which is a claim for interest on an allowed claim of Classes 1
- 4525 through 11, according to the terms of a plan to pay interest on allowed claims proposed by the
- 4526 liquidator and approved by the receivership court; and
- 4527 (m) subject to Subsection (4), a Class 13 claim, which is a claim of a shareholder or
- 4528 other owner arising out of:
- 4529 (i) the shareholder's or owner's capacity as shareholder or owner or any other capacity;
- 4530 and
- 4531 (ii) except as the claim may be qualified in Class 3, 4, 7, or 12.
- 4532 (3) To prove a claim described in Class 8, the claimant shall show that:
- 4533 (a) the insurer that is the subject of the delinquency proceeding incurred the fee or
- 4534 expense on the basis of the insurer's best knowledge, information, and belief:
- 4535 (i) formed after reasonable inquiry indicating opposition is in the best interests of the
- 4536 insurer;
- 4537 (ii) that is well grounded in fact; and
- 4538 (iii) is warranted by existing law or a good faith argument for the extension,
- 4539 modification, or reversal of existing law; and
- 4540 (b) opposition is not pursued for any improper purpose, such as to harass, to cause
- 4541 unnecessary delay, or to cause needless increase in the cost of the litigation.
- 4542 (4) (a) A claim in Class 11 is subject to a subordination agreement related to other
- 4543 claims in Class 11 that exist before the entry of a liquidation order.
- 4544 (b) A claim in Class 13 is subject to a subordination agreement, related to other claims
- 4545 in Class 13 that exist before the entry of a liquidation order.
- 4546 Section 44. Section **31A-29-106** is amended to read:
- 4547 **31A-29-106. Powers of board.**
- 4548 (1) The board shall have the general powers and authority granted under the laws of
- 4549 this state to insurance companies licensed to transact health care insurance business. In
- 4550 addition, the board shall have the specific authority to:
- 4551 (a) enter into contracts to carry out the provisions and purposes of this chapter,

- 4552 including, with the approval of the commissioner, contracts with:
- 4553 (i) similar pools of other states for the joint performance of common administrative
 - 4554 functions; or
 - 4555 (ii) persons or other organizations for the performance of administrative functions;
 - 4556 (b) sue or be sued, including taking such legal action necessary to avoid the payment of
 - 4557 improper claims against the pool or the coverage provided through the pool;
 - 4558 (c) establish appropriate rates, rate schedules, rate adjustments, expense allowances,
 - 4559 agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the
 - 4560 operation of the pool;
 - 4561 (d) issue policies of insurance in accordance with the requirements of this chapter;
 - 4562 (e) retain an executive director and appropriate legal, actuarial, and other personnel as
 - 4563 necessary to provide technical assistance in the operations of the pool;
 - 4564 (f) establish rules, conditions, and procedures for reinsuring risks under this chapter;
 - 4565 (g) cause the pool to have an annual audit of its operations by the state auditor;
 - 4566 (h) coordinate with the Department of Health in seeking to obtain from the Centers for
 - 4567 Medicare and Medicaid Services, or other appropriate office or agency of government, all
 - 4568 appropriate waivers, authority, and permission needed to coordinate the coverage available
 - 4569 from the pool with coverage available under Medicaid, either before or after Medicaid
 - 4570 coverage, or as a conversion option upon completion of Medicaid eligibility, without the
 - 4571 necessity for requalification by the enrollee;
 - 4572 (i) provide for and employ cost containment measures and requirements including
 - 4573 preadmission certification, concurrent inpatient review, and individual case management for
 - 4574 the purpose of making the pool more cost-effective;
 - 4575 (j) offer pool coverage through contracts with health maintenance organizations,
 - 4576 preferred provider organizations, and other managed care systems that will manage costs while
 - 4577 maintaining quality care;
 - 4578 (k) establish annual limits on benefits payable under the pool to or on behalf of any
 - 4579 enrollee;
 - 4580 (l) exclude from coverage under the pool specific benefits, medical conditions, and
 - 4581 procedures for the purpose of protecting the financial viability of the pool;
 - 4582 (m) administer the Pool Fund;

4583 (n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative
4584 Rulemaking Act, to implement this chapter;

4585 (o) adopt, trademark, and copyright a trade name for the pool for use in marketing and
4586 publicizing the pool and its products; and

4587 (p) transition health care coverage for all individuals covered under the pool as part of
4588 the conversion to health insurance coverage, regardless of preexisting conditions, under
4589 PPACA.

4590 (2) (a) The board shall prepare and submit an annual report to the Legislature which
4591 shall include:

4592 (i) the net premiums anticipated;

4593 (ii) actuarial projections of payments required of the pool;

4594 (iii) the expenses of administration; and

4595 (iv) the anticipated reserves or losses of the pool.

4596 (b) The budget for operation of the pool is subject to the approval of the board.

4597 (c) The administrative budget of the board and the commissioner under this chapter
4598 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is
4599 subject to review and approval by the Legislature.

4600 ~~[(3)(a) The board shall on or before September 1, 2004, require the plan administrator~~
4601 ~~or an independent actuarial consultant retained by the plan administrator to redetermine the~~
4602 ~~reasonable equivalent of the criteria for uninsurability required under Subsection~~
4603 ~~31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.]~~

4604 ~~[(b) The board shall redetermine the criteria established in Subsection (3)(a) at least~~
4605 ~~every five years thereafter.]~~

4606 Section 45. Section **31A-29-111** is amended to read:

4607 **31A-29-111. Eligibility -- Limitations.**

4608 (1) (a) Except as provided in Subsection (1)(b), an individual who is not HIPAA
4609 eligible is eligible for pool coverage if the individual:

4610 (i) pays the established premium;

4611 (ii) is a resident of this state; and

4612 (iii) meets the health underwriting criteria under Subsection (5)(a).

4613 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not

4614 eligible for pool coverage if one or more of the following conditions apply:

4615 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
4616 except as provided in Section 31A-29-112;

4617 (ii) the individual has terminated coverage in the pool, unless:

4618 (A) 12 months have elapsed since the termination date; or

4619 (B) the individual demonstrates that creditable coverage has been involuntarily
4620 terminated for any reason other than nonpayment of premium;

4621 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

4622 (iv) the individual is an inmate of a public institution;

4623 (v) the individual is eligible for a public health plan, as defined in federal regulations
4624 adopted pursuant to 42 U.S.C. Sec. 300gg;

4625 (vi) the individual's health condition does not meet the criteria established under
4626 Subsection (5);

4627 (vii) the individual is eligible for coverage under an employer group that offers a health
4628 benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members
4629 as:

4630 (A) an eligible employee;

4631 (B) a dependent of an eligible employee; or

4632 (C) a member;

4633 (viii) the individual is covered under any other health benefit plan;

4634 (ix) except as provided in Subsections (3) and (6), at the time of application, the
4635 individual has not resided in Utah for at least 12 consecutive months preceding the date of
4636 application; or

4637 (x) the individual's employer pays any part of the individual's health benefit plan
4638 premium, either as an insured or a dependent, for pool coverage.

4639 (2) (a) Except as provided in Subsection (2)(b), an individual who is HIPAA eligible is
4640 eligible for pool coverage if the individual:

4641 (i) pays the established premium; and

4642 (ii) is a resident of this state.

4643 (b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for
4644 pool coverage if one or more of the following conditions apply:

- 4645 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
4646 except as provided in Section 31A-29-112;
- 4647 (ii) the individual is eligible for a public health plan, as defined in federal regulations
4648 adopted pursuant to 42 U.S.C. Sec. 300gg;
- 4649 (iii) the individual is covered under any other health benefit plan;
- 4650 (iv) the individual is eligible for coverage under an employer group that offers a health
4651 benefit plan or self-insurance arrangements to its eligible employees, dependents, or members
4652 as:
- 4653 (A) an eligible employee;
- 4654 (B) a dependent of an eligible employee; or
- 4655 (C) a member;
- 4656 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;
- 4657 (vi) the individual is an inmate of a public institution; or
- 4658 (vii) the individual's employer pays any part of the individual's health benefit plan
4659 premium, either as an insured or a dependent, for pool coverage.
- 4660 (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
4661 (1)(a), an individual whose health care insurance coverage from a state high risk pool with
4662 similar coverage is terminated because of nonresidency in another state is eligible for coverage
4663 under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).
- 4664 (b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the
4665 termination date of the previous high risk pool coverage.
- 4666 (c) The effective date of this state's pool coverage shall be the date of termination of
4667 the previous high risk pool coverage.
- 4668 (d) The waiting period of an individual with a preexisting condition applying for
4669 coverage under this chapter shall be waived:
- 4670 (i) to the extent to which the waiting period was satisfied under a similar plan from
4671 another state; and
- 4672 (ii) if the other state's benefit limitation was not reached.
- 4673 (4) (a) If an eligible individual applies for pool coverage within 30 days of being
4674 denied coverage by an individual carrier, the effective date for pool coverage shall be no later
4675 than the first day of the month following the date of submission of the completed insurance

4676 application to the carrier.

4677 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under
4678 Subsection (3), the effective date shall be the date of termination of the previous high risk pool
4679 coverage.

4680 (5) (a) The board shall establish and adjust, as necessary, health underwriting criteria
4681 based on:

4682 (i) health condition; and

4683 (ii) expected claims so that the expected claims are anticipated to remain within
4684 available funding.

4685 (b) The board, with approval of the commissioner, may contract with one or more
4686 providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting
4687 criteria under Subsection (5)(a).

4688 [~~(c) If an individual is denied coverage by the pool under the criteria established in~~
4689 ~~Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage~~
4690 ~~under Subsection 31A-30-108(3).]~~

4691 (6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
4692 (1)(a), an individual whose individual health care insurance coverage was involuntarily
4693 terminated, is eligible for coverage under the pool subject to the conditions of Subsections
4694 (1)(b)(i) through (viii) and (x).

4695 (b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the
4696 termination date of the previous individual health care insurance coverage.

4697 (c) The effective date of this state's pool coverage shall be the date of termination of
4698 the previous individual coverage.

4699 (d) The waiting period of an individual with a preexisting condition applying for
4700 coverage under this chapter shall be waived to the extent to which the waiting period was
4701 satisfied under the individual health insurance plan.

4702 Section 46. Section 31A-29-115 is amended to read:

4703 **31A-29-115. Cancellation -- Notice.**

4704 (1) [~~(a)~~] On the date of renewal, the pool may cancel an enrollee's policy if:

4705 [~~(i)~~] (a) the enrollee's health condition does not meet the criteria established in
4706 Subsection 31A-29-111(5); and

4707 [(ii)] (b) the pool has provided written notice to the enrollee's last-known address no
 4708 less than 60 days before cancellation[; and].

4709 [(iii) at least one individual carrier has not reached the individual enrollment cap
 4710 established in Section 31A-30-110.]

4711 [(b) The pool shall issue a certificate of insurability to an enrollee whose policy is
 4712 cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the
 4713 requirements of Subsection 31A-29-111(5) are met.]

4714 (2) The pool may cancel an enrollee's policy at any time if:

4715 (a) the pool has provided written notice to the enrollee's last-known address no less
 4716 than 15 days before cancellation; and

4717 (b) (i) the enrollee establishes a residency outside of Utah for three consecutive
 4718 months;

4719 (ii) there is nonpayment of premiums; or

4720 (iii) the pool determines that the enrollee does not meet the eligibility requirements set
 4721 forth in Section 31A-29-111, in which case:

4722 (A) the policy may be retroactively terminated for the period of time in which the
 4723 enrollee was not eligible;

4724 (B) retroactive termination may not exceed three years; and

4725 (C) the board's remedy under this Subsection (2)(b) shall be a cause of action against
 4726 the enrollee for benefits paid during the period of ineligibility in accordance with Subsection
 4727 31A-29-119(3).

4728 Section 47. Section 31A-30-102 is amended to read:

4729 **31A-30-102. Purpose statement.**

4730 The purpose of this chapter is to:

4731 (1) prevent abusive rating practices;

4732 (2) require disclosure of rating practices to purchasers;

4733 (3) establish rules regarding:

4734 (a) a universal individual and small group application; and

4735 (b) renewability of coverage;

4736 (4) improve the overall fairness and efficiency of the individual and small group
 4737 insurance market;

4738 (5) provide increased access for individuals and small employers to health insurance;
4739 and

4740 (6) provide an employer with the opportunity to establish a defined contribution
4741 arrangement for an employee to purchase a health benefit plan through the [~~Internet portal~~]
4742 Health Insurance Exchange created by Section [63M-1-2504](#).

4743 Section 48. Section **31A-30-103** is amended to read:

4744 **31A-30-103. Definitions.**

4745 As used in this chapter:

4746 (1) "Actuarial certification" means a written statement by a member of the American
4747 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
4748 is in compliance with [~~Sections 31A-30-106 and 31A-30-106.1~~] this chapter, based upon the
4749 examination of the covered carrier, including review of the appropriate records and of the
4750 actuarial assumptions and methods used by the covered carrier in establishing premium rates
4751 for applicable health benefit plans.

4752 (2) "Affiliate" or "affiliated" means [~~any entity or~~] a person who directly or indirectly
4753 through one or more intermediaries, controls or is controlled by, or is under common control
4754 with, a specified [~~entity or~~] person.

4755 (3) "Base premium rate" means, for each class of business as to a rating period, the
4756 lowest premium rate charged or that could have been charged under a rating system for that
4757 class of business by the covered carrier to covered insureds with similar case characteristics for
4758 health benefit plans with the same or similar coverage.

4759 (4) (a) "Bona fide employer association" means an association of employers:

4760 (i) that meets the requirements of Subsection [31A-22-701\(2\)\(b\)](#);

4761 (ii) in which the employers of the association, either directly or indirectly, exercise
4762 control over the plan;

4763 (iii) that is organized:

4764 (A) based on a commonality of interest between the employers and their employees
4765 that participate in the plan by some common economic or representation interest or genuine
4766 organizational relationship unrelated to the provision of benefits; and

4767 (B) to act in the best interests of its employers to provide benefits for the employer's
4768 employees and their spouses and dependents, and other benefits relating to employment; and

- 4769 (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.
- 4770 (b) The commissioner shall consider the following with regard to determining whether
- 4771 an association of employers is a bona fide employer association under Subsection (4)(a):
- 4772 (i) how association members are solicited;
- 4773 (ii) who participates in the association;
- 4774 (iii) the process by which the association was formed;
- 4775 (iv) the purposes for which the association was formed, and what, if any, were the
- 4776 pre-existing relationships of its members;
- 4777 (v) the powers, rights and privileges of employer members; and
- 4778 (vi) who actually controls and directs the activities and operations of the benefit
- 4779 programs.
- 4780 (5) "Carrier" means ~~[any]~~ a person ~~[or entity]~~ that provides health insurance in this
- 4781 state including:
- 4782 (a) an insurance company;
- 4783 (b) a prepaid hospital or medical care plan;
- 4784 (c) a health maintenance organization;
- 4785 (d) a multiple employer welfare arrangement; and
- 4786 (e) ~~[any other]~~ another person ~~[or entity]~~ providing a health insurance plan under this
- 4787 title.
- 4788 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
- 4789 demographic or other objective characteristics of a covered insured that are considered by the
- 4790 carrier in determining premium rates for the covered insured.
- 4791 (b) "Case characteristics" do not include:
- 4792 (i) duration of coverage since the policy was issued;
- 4793 (ii) claim experience; and
- 4794 (iii) health status.
- 4795 (7) "Class of business" means all or a separate grouping of covered insureds that is
- 4796 permitted by the commissioner in accordance with Section [31A-30-105](#).
- 4797 ~~[(8) "Conversion policy" means a policy providing coverage under the conversion~~
- 4798 ~~provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.]~~
- 4799 ~~[(9)]~~ (8) "Covered carrier" means ~~[any]~~ an individual carrier or small employer carrier

4800 subject to this chapter.

4801 ~~[(10)]~~ (9) "Covered individual" means ~~[any]~~ an individual who is covered under a
4802 health benefit plan subject to this chapter.

4803 ~~[(11)]~~ (10) "Covered insureds" means small employers and individuals who are issued
4804 a health benefit plan that is subject to this chapter.

4805 ~~[(12)]~~ (11) "Dependent" means an individual to the extent that the individual is defined
4806 to be a dependent by:

4807 (a) the health benefit plan covering the covered individual; and

4808 (b) Chapter 22, Part 6, Accident and Health Insurance.

4809 ~~[(13)]~~ (12) "Established geographic service area" means a geographical area approved
4810 by the commissioner within which the carrier is authorized to provide coverage.

4811 ~~[(14)]~~ (13) "Index rate" means, for each class of business as to a rating period for
4812 covered insureds with similar case characteristics, the arithmetic average of the applicable base
4813 premium rate and the corresponding highest premium rate.

4814 ~~[(15)]~~ (14) "Individual carrier" means a carrier that provides coverage on an individual
4815 basis through a health benefit plan regardless of whether:

4816 (a) coverage is offered through:

4817 (i) an association;

4818 (ii) a trust;

4819 (iii) a discretionary group; or

4820 (iv) other similar groups; or

4821 (b) the policy or contract is situated out-of-state.

4822 ~~[(16)]~~ (15) "Individual conversion policy" means a conversion policy issued to:

4823 (a) an individual; or

4824 (b) an individual with a family.

4825 ~~[(17)]~~ "Individual coverage count" means the number of natural persons covered under
4826 a carrier's health benefit products that are individual policies.]

4827 ~~[(18)]~~ "Individual enrollment cap" means the percentage set by the commissioner in
4828 accordance with Section ~~31A-30-110~~.]

4829 ~~[(19)]~~ (16) "New business premium rate" means, for each class of business as to a
4830 rating period, the lowest premium rate charged or offered, or that could have been charged or

4831 offered, by the carrier to covered insureds with similar case characteristics for newly issued
4832 health benefit plans with the same or similar coverage.

4833 ~~[(20)]~~ (17) "Premium" means money paid by covered insureds and covered individuals
4834 as a condition of receiving coverage from a covered carrier, including ~~[any]~~ fees or other
4835 contributions associated with the health benefit plan.

4836 ~~[(21)]~~ (18) (a) "Rating period" means the calendar period for which premium rates
4837 established by a covered carrier are assumed to be in effect, as determined by the carrier.

4838 (b) A covered carrier may not have:

4839 (i) more than one rating period in any calendar month; and

4840 (ii) no more than 12 rating periods in any calendar year.

4841 ~~[(22)]~~ "Resident" means an individual who has resided in this state for at least 12
4842 consecutive months immediately preceding the date of application.]

4843 ~~[(23)]~~ (19) "Short-term limited duration insurance" means a health benefit product that:

4844 (a) is not renewable; and

4845 (b) has an expiration date specified in the contract that is less than 364 days after the
4846 date the plan became effective.

4847 ~~[(24)]~~ (20) "Small employer carrier" means a carrier that provides health benefit plans
4848 covering eligible employees of one or more small employers in this state, regardless of
4849 whether:

4850 (a) coverage is offered through:

4851 (i) an association;

4852 (ii) a trust;

4853 (iii) a discretionary group; or

4854 (iv) other similar grouping; or

4855 (b) the policy or contract is situated out-of-state.

4856 ~~[(25)]~~ "Uninsurable" means an individual who:]

4857 ~~[(a)]~~ is eligible for the Comprehensive Health Insurance Pool coverage under the
4858 underwriting criteria established in Subsection ~~31A-29-111(5)~~; or]

4859 ~~[(b)(i)]~~ is issued a certificate for coverage under Subsection ~~31A-30-108(3)~~; and]

4860 ~~[(ii)]~~ has a condition of health that does not meet consistently applied underwriting
4861 criteria as established by the commissioner in accordance with Subsections ~~31A-30-106(1)(g)~~

4862 and (h) for which coverage the applicant is applying.]

4863 [(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
4864 purposes of this formula:]

4865 [(a) "CI" means the carrier's individual coverage count as of December 31 of the
4866 preceding year; and]

4867 [(b) "UC" means the number of uninsurable individuals who were issued an individual
4868 policy on or after July 1, 1997.]

4869 Section 49. Section **31A-30-104** is amended to read:

4870 **31A-30-104. Applicability and scope.**

4871 (1) This chapter applies to any:

4872 (a) health benefit plan that provides coverage to:

4873 (i) individuals;

4874 (ii) small employers, except as provided in Subsection (3); or

4875 (iii) both Subsections (1)(a)(i) and (ii); or

4876 (b) individual conversion policy for purposes of Sections [31A-30-106.5](#) and
4877 [31A-30-107.5](#).

4878 (2) This chapter applies to a health benefit plan that provides coverage to small
4879 employers or individuals regardless of:

4880 (a) whether the contract is issued to:

4881 (i) an association, except as provided in Subsection (3);

4882 (ii) a trust;

4883 (iii) a discretionary group; or

4884 (iv) other similar grouping; or

4885 (b) the situs of delivery of the policy or contract.

4886 (3) This chapter does not apply to:

4887 (a) short-term limited duration health insurance;

4888 (b) federally funded or partially funded programs; or

4889 (c) a bona fide employer association.

4890 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

4891 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
4892 return shall be treated as one carrier; and

4893 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
4894 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
4895 carriers were issued by one carrier.

4896 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
4897 maintenance organization having a certificate of authority under this title may be considered to
4898 be a separate carrier for the purposes of this chapter.

4899 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined
4900 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding
4901 arrangements with respect to health benefit plans delivered or issued for delivery to covered
4902 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
4903 obligation or risk for the health benefit plans being retained by the ceding carrier.

4904 (d) Section [31A-22-1201](#) applies if a covered carrier cedes or assumes all of the
4905 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
4906 for delivery to covered insureds in this state.

4907 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
4908 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
4909 may make a written request to the commissioner for a waiver from the application of any of the
4910 provisions of ~~[Subsection]~~ Subsections [31A-30-106\(1\)](#) and [31A-30-106.1\(1\)](#) with respect to a
4911 health benefit plan provided to the trust.

4912 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
4913 waiver if the commissioner finds that application with respect to the trust would:

4914 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
4915 and

4916 (ii) require significant modifications to one or more collective bargaining arrangements
4917 under which the trust is established or maintained.

4918 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
4919 person participates in a Taft Hartley trust as an associate member of any employee
4920 organization.

4921 (6) Sections [31A-30-106](#), [31A-30-106.1](#), [31A-30-106.5](#), [31A-30-106.7](#), [31A-30-107](#),
4922 and [31A-30-108](#), ~~[and [31A-30-111](#)]~~ apply to:

4923 (a) any insurer engaging in the business of insurance related to the risk of a small

4924 employer for medical, surgical, hospital, or ancillary health care expenses of the small
4925 employer's employees provided as an employee benefit; and

4926 (b) any contract of an insurer, other than a workers' compensation policy, related to the
4927 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the
4928 small employer's employees provided as an employee benefit.

4929 (7) The commissioner may make rules requiring that the marketing practices be
4930 consistent with this chapter for:

4931 (a) a small employer carrier;

4932 (b) a small employer carrier's agent;

4933 (c) an insurance producer;

4934 (d) an insurance consultant; and

4935 (e) a navigator.

4936 Section 50. Section **31A-30-106** is amended to read:

4937 **31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.**

4938 (1) Premium rates for health benefit plans for individuals under this chapter are subject
4939 to this section.

4940 (a) The index rate for a rating period for any class of business may not exceed the
4941 index rate for any other class of business by more than 20%.

4942 (b) (i) For a class of business, the premium rates charged during a rating period to
4943 covered insureds with similar case characteristics for the same or similar coverage, or the rates
4944 that could be charged to the individual under the rating system for that class of business, may
4945 not vary from the index rate by more than 30% of the index rate except as provided under
4946 Subsection (1)(b)(ii).

4947 (ii) A carrier that offers individual and small employer health benefit plans may use the
4948 small employer index rates to establish the rate limitations for individual policies, even if some
4949 individual policies are rated below the small employer base rate.

4950 (c) The percentage increase in the premium rate charged to a covered insured for a new
4951 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
4952 the following:

4953 (i) the percentage change in the new business premium rate measured from the first day
4954 of the prior rating period to the first day of the new rating period;

4955 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
4956 of less than one year, due to the claim experience, health status, or duration of coverage of the
4957 covered individuals as determined from the rate manual for the class of business of the carrier
4958 offering an individual health benefit plan; and

4959 (iii) any adjustment due to change in coverage or change in the case characteristics of
4960 the covered insured as determined from the rate manual for the class of business of the carrier
4961 offering an individual health benefit plan.

4962 (d) (i) A carrier offering an individual health benefit plan shall apply rating factors,
4963 including case characteristics, consistently with respect to all covered insureds in a class of
4964 business.

4965 (ii) Rating factors shall produce premiums for identical individuals that:

4966 (A) differ only by the amounts attributable to plan design; and

4967 (B) do not reflect differences due to the nature of the individuals assumed to select
4968 particular health benefit products.

4969 (iii) A carrier offering an individual health benefit plan shall treat all health benefit
4970 plans issued or renewed in the same calendar month as having the same rating period.

4971 (e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted
4972 network provision may not be considered similar coverage to a health benefit plan that does not
4973 use a restricted network provision, provided that use of the restricted network provision results
4974 in substantial difference in claims costs.

4975 (f) A carrier offering a health benefit plan to an individual may not, without prior
4976 approval of the commissioner, use case characteristics other than:

4977 (i) age;

4978 (ii) gender;

4979 (iii) geographic area; and

4980 (iv) family composition.

4981 (g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3,
4982 Utah Administrative Rulemaking Act, to:

4983 (A) implement this chapter; [~~and~~]

4984 (B) assure that rating practices used by carriers who offer health benefit plans to
4985 individuals are consistent with the purposes of this chapter[-]; and

4986 (C) promote transparency of rating practices of health benefit plans.

4987 (ii) The rules described in Subsection (1)(g)(i) may include rules that:

4988 (A) assure that differences in rates charged for health benefit products by carriers who
4989 offer health benefit plans to individuals are reasonable and reflect objective differences in plan
4990 design, not including differences due to the nature of the individuals assumed to select
4991 particular health benefit products; and

4992 (B) prescribe the manner in which case characteristics may be used by carriers who
4993 offer health benefit plans to individuals[;].

4994 [~~(C) implement the individual enrollment cap under Section 31A-30-110, including~~
4995 ~~specifying:]~~

4996 [~~(F) the contents for certification;]~~

4997 [~~(H) auditing standards;]~~

4998 [~~(HH) underwriting criteria for uninsurable classification; and]~~

4999 [~~(IV) limitations on high risk enrollees under Section 31A-30-111; and]~~

5000 [~~(D) establish the individual enrollment cap under Subsection 31A-30-110(1).]~~

5001 [~~(h) Before implementing regulations for underwriting criteria for uninsurable~~
5002 ~~classification, the commissioner shall contract with an independent consulting organization to~~
5003 ~~develop industry-wide underwriting criteria for uninsurability based on an individual's expected~~
5004 ~~claims under open enrollment coverage exceeding 325% of that expected for a standard~~
5005 ~~insurable individual with the same case characteristics.]~~

5006 [(i) (h) The commissioner shall revise rules issued for Sections 31A-22-602 and
5007 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance
5008 with this section.

5009 (2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit
5010 product into which the covered carrier is no longer enrolling new covered insureds, the covered
5011 carrier shall use the percentage change in the base premium rate, provided that the change does
5012 not exceed, on a percentage basis, the change in the new business premium rate for the most
5013 similar health benefit product into which the covered carrier is actively enrolling new covered
5014 insureds.

5015 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of
5016 a class of business.

5017 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
5018 of business unless the offer is made to transfer all covered insureds in the class of business
5019 without regard to:

- 5020 (i) case characteristics;
- 5021 (ii) claim experience;
- 5022 (iii) health status; or
- 5023 (iv) duration of coverage since issue.

5024 (4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the
5025 carrier's principal place of business a complete and detailed description of its rating practices
5026 and renewal underwriting practices, including information and documentation that demonstrate
5027 that the carrier's rating methods and practices are:

- 5028 (i) based upon commonly accepted actuarial assumptions; and
- 5029 (ii) in accordance with sound actuarial principles.

5030 (b) (i) ~~Each~~ A carrier subject to this section shall file with the commissioner, on or
5031 before April 1 of each year, in a form, manner, and containing such information as prescribed
5032 by the commissioner, an actuarial certification certifying that:

- 5033 (A) the carrier is in compliance with this chapter; and
- 5034 (B) the rating methods of the carrier are actuarially sound.

5035 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the
5036 carrier at the carrier's principal place of business.

5037 (c) A carrier shall make the information and documentation described in this
5038 Subsection (4) available to the commissioner upon request.

5039 (d) ~~Records~~ Except as provided in Subsection (1)(g) or required by PPACA, a record
5040 submitted to the commissioner under this section shall be maintained by the commissioner as a
5041 protected ~~records~~ record under Title 63G, Chapter 2, Government Records Access and
5042 Management Act.

5043 Section 51. Section **31A-30-106.7** is amended to read:

5044 **31A-30-106.7. Surcharge for groups changing carriers.**

5045 (1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered
5046 carrier may impose upon a small group that changes coverage to that carrier from another
5047 carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could

5048 otherwise charge under Section [~~31A-30-106~~] 31A-30-106.1.

5049 (b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

5050 (i) the change in carriers occurs on the anniversary of the plan year, as defined in

5051 Section 31A-1-301;

5052 (ii) the previous coverage was terminated under Subsection 31A-30-107(3)(e); [~~or~~]

5053 (iii) employees from an existing group form a new business[-]; and

5054 (iv) the surcharge is not applied uniformly to all similarly situated small groups.

5055 (2) A covered carrier may not impose the surcharge described in Subsection (1) if the

5056 offer to cover the group occurs at a time other than the anniversary of the plan year because:

5057 (a) (i) the application for coverage is made prior to the anniversary date in accordance

5058 with the covered carrier's published policies; and

5059 (ii) the offer to cover the group is not issued until after the anniversary date; or

5060 (b) (i) the application for coverage is made prior to the anniversary date in accordance

5061 with the covered carrier's published policies; and

5062 (ii) additional underwriting or rating information requested by the covered carrier is not

5063 received until after the anniversary date.

5064 (3) If a covered carrier chooses to apply a surcharge under Subsection (1), the

5065 application of the surcharge and the criteria for incurring or avoiding the surcharge shall be

5066 clearly stated in the:

5067 (a) written application materials provided to the applicant at the time of application;

5068 and

5069 (b) written producer guidelines.

5070 (4) The commissioner shall adopt rules in accordance with Title 63G, Chapter 3, Utah

5071 Administrative Rulemaking Act, to ensure compliance with this section.

5072 Section 52. Section **31A-30-107** is amended to read:

5073 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**

5074 **nonrenewal.**

5075 (1) Except as otherwise provided in this section, a small employer health benefit plan is
5076 renewable and continues in force:

5077 (a) with respect to all eligible employees and dependents; and

5078 (b) at the option of the plan sponsor.

- 5079 (2) A small employer health benefit plan may be discontinued or nonrenewed:
- 5080 (a) for a network plan, if~~[-(i)]~~ there is no longer any enrollee under the group health
- 5081 plan who lives, resides, or works in:
- 5082 ~~[(A)]~~ (i) the service area of the covered carrier; or
- 5083 ~~[(B)]~~ (ii) the area for which the covered carrier is authorized to do business; ~~[and] or~~
- 5084 ~~[(ii) in the case of the small employer market, the small employer carrier applies the~~
- 5085 ~~same criteria the small employer carrier would apply in denying enrollment in the plan under~~
- 5086 ~~Subsection 31A-30-108(7); or]~~
- 5087 (b) for coverage made available in the small or large employer market only through an
- 5088 association, if:
- 5089 (i) the employer's membership in the association ceases; and
- 5090 (ii) the coverage is terminated uniformly without regard to any health status-related
- 5091 factor relating to any covered individual.
- 5092 (3) A small employer health benefit plan may be discontinued if:
- 5093 (a) a condition described in Subsection (2) exists;
- 5094 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay
- 5095 premiums or contributions in accordance with the terms of the contract;
- 5096 (c) the plan sponsor:
- 5097 (i) performs an act or practice that constitutes fraud; or
- 5098 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 5099 coverage;
- 5100 (d) the covered carrier:
- 5101 (i) elects to discontinue offering a particular small employer health benefit product
- 5102 delivered or issued for delivery in this state; and
- 5103 (ii) (A) provides notice of the discontinuation in writing:
- 5104 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
- 5105 (II) at least 90 days before the date the coverage will be discontinued;
- 5106 (B) provides notice of the discontinuation in writing:
- 5107 (I) to the commissioner; and
- 5108 (II) at least three working days prior to the date the notice is sent to the affected plan
- 5109 sponsors, employees, and dependents of the plan sponsors or employees;

5110 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all
5111 other small employer health benefit products currently being offered by the small employer
5112 carrier in the market; and

5113 (D) in exercising the option to discontinue that product and in offering the option of
5114 coverage in this section, acts uniformly without regard to:

5115 (I) the claims experience of a plan sponsor;

5116 (II) any health status-related factor relating to any covered participant or beneficiary; or

5117 (III) any health status-related factor relating to any new participant or beneficiary who
5118 may become eligible for the coverage; or

5119 (e) the covered carrier:

5120 (i) elects to discontinue all of the covered carrier's small employer health benefit plans
5121 in:

5122 (A) the small employer market;

5123 (B) the large employer market; or

5124 (C) both the small employer and large employer markets; and

5125 (ii) (A) provides notice of the discontinuation in writing:

5126 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

5127 (II) at least 180 days before the date the coverage will be discontinued;

5128 (B) provides notice of the discontinuation in writing:

5129 (I) to the commissioner in each state in which an affected insured individual is known
5130 to reside; and

5131 (II) at least 30 working days prior to the date the notice is sent to the affected plan
5132 sponsors, employees, and the dependents of the plan sponsors or employees;

5133 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
5134 market; and

5135 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).

5136 (4) A small employer health benefit plan may be discontinued or nonrenewed:

5137 (a) if a condition described in Subsection (2) exists; or

5138 (b) except as prohibited by Section [31A-30-206](#), for noncompliance with the insurer's
5139 employer contribution requirements.

5140 (5) A small employer health benefit plan may be nonrenewed:

5141 (a) if a condition described in Subsection (2) exists; or
5142 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
5143 minimum participation requirements.

5144 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
5145 discontinued if after issuance of coverage the eligible employee:

5146 (i) engages in an act or practice that constitutes fraud in connection with the coverage;

5147 or

5148 (ii) makes an intentional misrepresentation of material fact in connection with the
5149 coverage.

5150 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

5151 (i) 12 months after the date of discontinuance; and

5152 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
5153 to reenroll.

5154 (c) At the time the eligible employee's coverage is discontinued under Subsection
5155 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
5156 coverage is discontinued.

5157 (d) An eligible employee may not be discontinued under this Subsection (6) because of
5158 a fraud or misrepresentation that relates to health status.

5159 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
5160 the employer:

5161 (a) with respect to coverage provided to an employer member of the association; and

5162 (b) if the small employer health benefit plan is made available by a covered carrier in
5163 the employer market only through:

5164 (i) an association;

5165 (ii) a trust; or

5166 (iii) a discretionary group.

5167 (8) A covered carrier may modify a small employer health benefit plan only:

5168 (a) at the time of coverage renewal; and

5169 (b) if the modification is effective uniformly among all plans with that product.

5170 Section 53. Section 31A-30-108 is amended to read:

5171 **31A-30-108. Eligibility for small employer and individual market.**

5172 (1) (a) ~~[Small employer carriers shall accept residents]~~ A small employer carrier shall
5173 accept a small employer that applies for small group coverage as set forth in the Health
5174 Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a), and PPACA, Sec.
5175 2702.

5176 ~~[(b) Individual carriers shall accept residents for individual coverage pursuant to:]~~
5177 ~~[(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and]~~
5178 ~~[(ii) Subsection (3).]~~

5179 (b) An individual carrier shall accept an individual that applies for individual coverage
5180 as set forth in PPACA, Section 2702.

5181 (2) (a) ~~[Small]~~ A small employer ~~[carriers]~~ carrier shall offer to accept all eligible
5182 employees and their dependents at the same level of benefits under any health benefit plan
5183 provided to a small employer.

5184 (b) ~~[Small]~~ A small employer ~~[carriers]~~ carrier may:

5185 (i) request a small employer to submit a copy of the small employer's quarterly income
5186 tax withholdings to determine whether the employees for whom coverage is provided or
5187 requested are bona fide employees of the small employer; and

5188 (ii) deny or terminate coverage if the small employer refuses to provide documentation
5189 requested under Subsection (2)(b)(i).

5190 ~~[(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual~~
5191 ~~carriers shall accept for coverage individuals to whom all of the following conditions apply:]~~

5192 ~~[(a) the individual is not covered or eligible for coverage:]~~

5193 ~~[(i) (A) as an employee of an employer;]~~

5194 ~~[(B) as a member of an association; or]~~

5195 ~~[(C) as a member of any other group; and]~~

5196 ~~[(ii) under:]~~

5197 ~~[(A) a health benefit plan; or]~~

5198 ~~[(B) a self-insured arrangement that provides coverage similar to that provided by a~~
5199 ~~health benefit plan as defined in Section 31A-1-301;]~~

5200 ~~[(b) the individual is not covered and is not eligible for coverage under any public~~
5201 ~~health benefits arrangement including:]~~

5202 ~~[(i) the Medicare program established under Title XVIII of the Social Security Act;]~~

5203 ~~[(ii) any act of Congress or law of this or any other state that provides benefits~~
5204 ~~comparable to the benefits provided under this chapter; or]~~

5205 ~~[(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter~~
5206 ~~29, Comprehensive Health Insurance Pool Act;]~~

5207 ~~[(c) unless the maximum benefit has been reached the individual is not covered or~~
5208 ~~eligible for coverage under any:]~~

5209 ~~[(i) Medicare supplement policy;]~~

5210 ~~[(ii) conversion option;]~~

5211 ~~[(iii) continuation or extension under COBRA; or]~~

5212 ~~[(iv) state extension;]~~

5213 ~~[(d) the individual has not terminated or declined coverage described in Subsection~~
5214 ~~(3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for~~
5215 ~~individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b),~~
5216 ~~in which case, the requirement of this Subsection (3)(d) does not apply; and]~~

5217 ~~[(e) the individual is certified as ineligible for the Health Insurance Pool if:]~~

5218 ~~[(i) the individual applies for coverage with the Comprehensive Health Insurance Pool~~
5219 ~~within 30 days after being rejected or refused coverage by the covered carrier and reapplies for~~
5220 ~~coverage with that covered carrier within 30 days after the date of issuance of a certificate~~
5221 ~~under Subsection [31A-29-111\(5\)\(c\)](#); or]~~

5222 ~~[(ii) the individual applies for coverage with any individual carrier within 45 days~~
5223 ~~after:]~~

5224 ~~[(A) notice of cancellation of coverage under Subsection [31A-29-115\(1\)](#); or]~~

5225 ~~[(B) the date of issuance of a certificate under Subsection [31A-29-111\(5\)\(c\)](#) if the~~
5226 ~~individual applied first for coverage with the Comprehensive Health Insurance Pool:]~~

5227 ~~[(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is~~
5228 ~~paid, the effective date of coverage shall be the first day of the month following the individual's~~
5229 ~~submission of a completed insurance application to that covered carrier:]~~

5230 ~~[(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is~~
5231 ~~paid, the effective date of coverage shall be the day following the:]~~

5232 ~~[(i) cancellation of coverage under Subsection [31A-29-115\(1\)](#); or]~~

5233 ~~[(ii) submission of a completed insurance application to the Comprehensive Health~~

5234 Insurance Pool;]

5235 ~~[(5) (a) An individual carrier is not required to accept individuals for coverage under~~
5236 ~~Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.]~~

5237 ~~[(b) A carrier described in Subsection (5)(a) may not issue new individual policies in~~
5238 ~~the state for five years from July 1, 1997.]~~

5239 ~~[(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new~~
5240 ~~policies after July 1, 1999, which may only be granted if:]~~

5241 ~~[(i) the carrier accepts uninsurables as is required of a carrier entering the market under~~
5242 ~~Subsection ~~31A-30-110~~; and]~~

5243 ~~[(ii) the commissioner finds that the carrier's issuance of new individual policies:]~~

5244 ~~[(A) is in the best interests of the state; and]~~

5245 ~~[(B) does not provide an unfair advantage to the carrier.]~~

5246 ~~[(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29,~~
5247 ~~Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is~~
5248 ~~capped or suspended, an individual carrier may decline to accept individuals applying for~~
5249 ~~individual enrollment, other than individuals applying for coverage as set forth in Health~~
5250 ~~Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).]~~

5251 ~~[(b) Within two calendar days of taking action under Subsection (6)(a), an individual~~
5252 ~~carrier will provide written notice to the department.]~~

5253 ~~[(7) (a) If a small employer carrier offers health benefit plans to small employers~~
5254 ~~through a network plan, the small employer carrier may:]~~

5255 ~~[(i) limit the employers that may apply for the coverage to those employers with~~
5256 ~~eligible employees who live, reside, or work in the service area for the network plan; and]~~

5257 ~~[(ii) within the service area of the network plan, deny coverage to an employer if the~~
5258 ~~small employer carrier has demonstrated to the commissioner that the small employer carrier:]~~

5259 ~~[(A) will not have the capacity to deliver services adequately to enrollees of any~~
5260 ~~additional groups because of the small employer carrier's obligations to existing group contract~~
5261 ~~holders and enrollees; and]~~

5262 ~~[(B) applies this section uniformly to all employers without regard to:]~~

5263 ~~[(f) the claims experience of an employer, an employer's employee, or a dependent of~~
5264 ~~an employee; or]~~

5265 ~~[(H) any health status-related factor relating to an employee or dependent of an~~
5266 ~~employee.]~~

5267 ~~[(b) (i) A small employer carrier that denies a health benefit product to an employer in~~
5268 ~~any service area in accordance with this section may not offer coverage in the small employer~~
5269 ~~market within the service area to any employer for a period of 180 days after the date the~~
5270 ~~coverage is denied.]~~

5271 ~~[(ii) This Subsection (7)(b) does not:]~~

5272 ~~[(A) limit the small employer carrier's ability to renew coverage that is in force; or]~~

5273 ~~[(B) relieve the small employer carrier of the responsibility to renew coverage that is in~~
5274 ~~force.]~~

5275 ~~[(c) Coverage offered within a service area after the 180-day period specified in~~
5276 ~~Subsection (7)(b) is subject to the requirements of this section.]~~

5277 Section 54. Section **31A-30-207** is amended to read:

5278 **31A-30-207. Rating and underwriting restrictions for health plans in the defined**
5279 **contribution arrangement market.**

5280 (1) Except as provided in Subsection (2), rating and underwriting restrictions for
5281 defined contribution arrangement health benefit plans offered in the Health Insurance
5282 Exchange shall be in accordance with Section **31A-30-106.1**, and the plan adopted under
5283 Chapter 42, Defined Contribution Risk Adjuster Act.

5284 (2) Notwithstanding ~~[the provisions of]~~ Subsections **31A-30-106.1**(9)(b)(ii) and (iii), a
5285 carrier offering a defined contribution arrangement in the Health Insurance Exchange under
5286 this part~~[-(a)]~~ shall calculate rates based on a family tier rating structure that includes four tiers
5287 in compliance with Subsection **31A-30-106.1**(9)(b)(i)~~[-and]~~.

5288 ~~[(b) may not calculate rates based on a family tier rating structure that includes five or~~
5289 ~~six tiers as described in Subsection **31A-30-106**(9)(b)(ii) or (iii).]~~

5290 (3) All insurers who participate in the defined contribution market shall:

5291 (a) participate in the risk adjuster mechanism developed under Chapter 42, Defined
5292 Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

5293 (b) provide the risk adjuster board with:

5294 (i) an employer group's risk factor; and

5295 (ii) carrier enrollment data; and

5296 (c) submit rates to the exchange that are net of commissions.

5297 (4) When an employer group enters the defined contribution arrangement market and
5298 the employer group has a health plan with an insurer who is participating in the defined
5299 contribution arrangement market, the risk factor applied to the employer group when it enters
5300 the defined contribution arrangement market may not be greater than the employer group's
5301 renewal risk factor for the same group of covered employees and the same effective date, as
5302 determined by the employer group's insurer.

5303 Section 55. Section 31A-30-209 is amended to read:

5304 **31A-30-209. Appointment of insurance producers to Health Insurance Exchange.**

5305 (1) A producer may be listed on the Health Insurance Exchange as a credentialed
5306 producer [~~for the defined contribution arrangement market in accordance with Section~~
5307 63M-1-2504], if the producer is designated as [~~an appointed~~] a credentialed agent for the
5308 [~~defined contribution arrangement market~~] Health Insurance Exchange in accordance with
5309 Subsection (2).

5310 (2) A producer whose license under this title authorizes the producer to sell [~~defined~~
5311 ~~contribution arrangement health benefit plans may be appointed to the defined contribution~~
5312 ~~arrangement market on~~] accident and health insurance may be credentialed by the Health
5313 Insurance Exchange [~~by the Insurance Department~~] and may sell any product on the Health
5314 Insurance Exchange, if the producer:

5315 [~~(a) submits an application to the Insurance Department to be appointed as a producer~~
5316 ~~for the defined contribution arrangement market on the Health Insurance Exchange;~~]

5317 [~~(b) is an appointed agent in accordance with Subsection (3), for products offered in~~
5318 ~~the defined contribution arrangement market of the Health Insurance Exchange, with the~~
5319 ~~carriers that offer a defined contribution arrangement health benefit plan on the Health~~
5320 ~~Insurance Exchange; and]~~

5321 [~~(c) has completed continuing education for the defined contribution arrangement~~
5322 ~~market that:]~~

5323 [~~(i) is required by administrative rule adopted by the commissioner; and]~~

5324 [~~(ii) provides training on premium assistance programs.]~~

5325 (a) is an appointed producer with:

5326 (i) all carriers that offer a plan in the defined contribution market on the Health

5327 Insurance Exchange; and

5328 (ii) at least one carrier that offers a dental plan on the Health Insurance Exchange; and

5329 (b) completes each year the Health Insurance Exchange training that includes training
 5330 on premium assistance programs.

5331 (3) A carrier shall appoint a producer to sell the carrier's products in the defined
 5332 contribution arrangement market of the Health Insurance Exchange, within 30 days of the
 5333 notice required in Subsection (3)(b), if:

5334 (a) the producer is currently appointed by a majority of the carriers in the Health
 5335 Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange;
 5336 and

5337 (b) the producer informs the carrier that the producer is:

5338 (i) applying to be appointed to the defined contribution arrangement market in the
 5339 Health Insurance Exchange;

5340 (ii) appointed by a majority of the carriers in the defined contribution arrangement
 5341 market in the Health Insurance Exchange;

5342 (iii) willing to complete training regarding the carrier's products offered on the defined
 5343 contribution arrangement market in the Health Insurance Exchange; and

5344 (iv) willing to sign the contracts and business associate's agreements that the carrier
 5345 requires for appointed producers in the Health Insurance Exchange.

5346 Section 56. Section **31A-30-211** is amended to read:

5347 **31A-30-211. Insurer disclosure.**

5348 [~~(1) The Health Insurance Exchange shall provide an employer's producer with the~~
 5349 ~~group's risk factor used to calculate the employer group's premium at the time of:]~~

5350 [~~(a) the initial offering of a health benefit plan; and]~~

5351 [~~(b) the renewal of a health benefit plan.]~~

5352 [~~(2) For health benefit plans that renew on or after March 1, 2012:]~~

5353 (1) (a) [~~a~~] A carrier shall provide an employer and the employer's producer with
 5354 premium renewal rates at least 60 days [~~prior to~~] before the group's renewal date for a plan
 5355 offered under Part 1, Individual and Small Employer Group[~~; and~~].

5356 (b) [~~the~~] The Health Insurance Exchange shall provide an employer and the employer's
 5357 producer with premium renewal rates at least 60 days [~~prior to~~] before the group's renewal date

5358 for a plan offered under Part 2, Defined Contribution Arrangements.

5359 ~~[(3)]~~ (2) An insurer does not have to provide additional notice of premium renewal
5360 rates to the employer or the employer's producer if the Health Insurance Exchange provides
5361 notice in accordance with Subsection ~~[(2)]~~ (1)(b).

5362 Section 57. Section **31A-37-501** is amended to read:

5363 **31A-37-501. Reports to commissioner.**

5364 (1) A captive insurance company is not required to make a report except those
5365 provided in this chapter.

5366 (2) (a) Before March 1 of each year, a captive insurance company shall submit to the
5367 commissioner a report of the financial condition of the captive insurance company, verified by
5368 oath of two of the executive officers of the captive insurance company.

5369 (b) Except as provided in Sections [31A-37-204](#) and [31A-37-205](#), a captive insurance
5370 company shall report:

5371 (i) using generally accepted accounting principles, except to the extent that the
5372 commissioner requires, approves, or accepts the use of a statutory accounting principle;

5373 (ii) using a useful or necessary modification or adaptation to an accounting principle
5374 that is required, approved, or accepted by the commissioner for the type of insurance and kind
5375 of insurer to be reported upon; and

5376 (iii) supplemental or additional information required by the commissioner.

5377 (c) Except as otherwise provided:

5378 (i) ~~[an association captive insurance company and an industrial insured group]~~ a
5379 licensed captive insurance company shall file the report required by Section [31A-4-113](#); and

5380 (ii) an industrial insured group shall comply with Section [31A-4-113.5](#).

5381 (3) (a) A pure captive insurance company may make written application to file the
5382 required report on a fiscal year end that is consistent with the fiscal year of the parent company
5383 of the pure captive insurance company.

5384 (b) If the commissioner grants an alternative reporting date for a pure captive insurance
5385 company requested under Subsection (3)(a), the annual report is due 60 days after the fiscal
5386 year end.

5387 (4) (a) Sixty days after the fiscal year end, a branch captive insurance company shall
5388 file with the commissioner a copy of ~~[aH]~~ the reports and statements required to be filed under

5389 the laws of the jurisdiction in which the alien captive insurance company is formed, verified by
5390 oath by two of the alien captive insurance company's executive officers.

5391 (b) If the commissioner is satisfied that the annual report filed by the alien captive
5392 insurance company in the jurisdiction in which the alien captive insurance company is formed
5393 provides adequate information concerning the financial condition of the alien captive insurance
5394 company, the commissioner may waive the requirement for completion of the annual statement
5395 required for a captive insurance company under this section with respect to business written in
5396 the alien jurisdiction.

5397 (c) A waiver by the commissioner under Subsection (4)(b):

5398 (i) shall be in writing; and

5399 (ii) is subject to public inspection.

5400 Section 58. Section **31A-40-203** is amended to read:

5401 **31A-40-203. Covered employee.**

5402 (1) (a) An individual is a covered employee of a professional employer organization if
5403 the individual is coemployed pursuant to a professional employer agreement subject to this
5404 chapter.

5405 (b) An individual who is a covered employee under a professional employer agreement
5406 is a covered ~~[employer]~~ employee, whether or not the professional employer organization
5407 provides the notice required by Subsection [31A-40-202\(3\)](#), the earlier of the day on which:

5408 (i) the employee is first compensated by the professional employer organization; or

5409 (ii) the client notifies the professional employer organization of a new hire.

5410 (2) An individual who is an officer, director, shareholder, partner, or manager of a
5411 client is a covered employee:

5412 (a) to the extent that the client and the professional employer organization expressly
5413 agree in the professional employer agreement that the individual is a covered employee;

5414 (b) if the conditions of Subsection (1) are met; and

5415 (c) if the individual acts as an operational manager or performs day-to-day an
5416 operational service for the client.

5417 Section 59. Section **31A-40-209** is amended to read:

5418 **31A-40-209. Workers' compensation.**

5419 (1) In accordance with Section [34A-2-103](#), a client is responsible for securing workers'

5420 compensation coverage for a covered employee.

5421 (2) Subject to the requirements of Section 34A-2-103, if a professional employer
5422 organization obtains or assists a client in obtaining workers' compensation insurance pursuant
5423 to a professional employer agreement:

5424 (a) the professional employer organization shall ensure that the client maintains and
5425 provides workers' compensation coverage for a covered employee in accordance with
5426 Subsection 34A-2-201(1) or (2) and rules of the Labor Commission, made in accordance with
5427 Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

5428 (b) the workers' compensation coverage may show the professional employer
5429 organization as the named insured through a [~~multiple coordinated~~] master policy, if:

5430 (i) the client is shown as an insured by means of an endorsement for each individual
5431 client;

5432 (ii) the experience modification of a client is used; and

5433 (iii) the insurer files the endorsement with the Division of Industrial Accidents as
5434 directed by a rule of the Labor Commission, made in accordance with Title 63G, Chapter 3,
5435 Utah Administrative Rulemaking Act;

5436 (c) at the termination of the professional employer agreement, if requested by the
5437 client, the insurer shall provide the client records regarding the loss experience related to
5438 workers' compensation insurance provided to a covered employee pursuant to the professional
5439 employer agreement; and

5440 (d) the insurer shall notify a client if the workers' compensation coverage for the client
5441 is terminated.

5442 (3) In accordance with Section 34A-2-105, the exclusive remedy provisions of Section
5443 34A-2-105 apply to both the client and the professional employer organization under a
5444 professional employer agreement regulated under this chapter.

5445 (4) Notwithstanding the other provisions in this section, an insurer may choose whether
5446 to issue:

5447 (a) a policy for a client; or

5448 (b) a [~~multiple coordinated~~] master policy with the client shown as an additional
5449 insured by means of an individual endorsement.

5450 Section 60. Section 31A-42-202 is amended to read:

5451 **31A-42-202. Contents of plan.**

5452 (1) The board shall submit a plan of operation for the risk adjuster to the
5453 commissioner. The plan shall:

5454 (a) establish the methodology for implementing:

5455 (i) Subsection (2) for the defined contribution arrangement market established under
5456 Chapter 30, Part 2, Defined Contribution Arrangements; and

5457 (ii) the participation of small employer group defined contribution arrangement health
5458 benefit plans;

5459 (b) establish regular times and places for meetings of the board;

5460 (c) establish procedures for keeping records of all financial transactions and for
5461 sending annual fiscal reports to the commissioner;

5462 (d) contain additional provisions necessary and proper for the execution of the powers
5463 and duties of the risk adjuster; and

5464 (e) establish procedures in compliance with Title 63A, Utah Administrative Services
5465 Code, to pay for administrative expenses incurred.

5466 (2) (a) The plan adopted by the board for the defined contribution arrangement market
5467 shall include:

5468 (i) parameters an employer may use to designate eligible employees for the defined
5469 contribution arrangement market; and

5470 (ii) underwriting mechanisms and employer eligibility guidelines:

5471 (A) consistent with the federal Health Insurance Portability and Accountability Act;
5472 and

5473 (B) necessary to protect insurance carriers from adverse selection in the defined
5474 contribution market.

5475 (b) The plan required by Subsection (2)(a) shall outline how premium rates for a
5476 qualified individual in the defined contribution arrangement market are determined, including:

5477 (i) the identification of an initial rate for a qualified individual based on:

5478 (A) standardized age bands submitted by participating insurers; and

5479 (B) wellness incentives for the individual as permitted by federal law; and

5480 (ii) the identification of a group risk factor to be applied to the initial age rate of a
5481 qualified individual based on the health conditions of all qualified individuals in the same

5482 employer group and, for small employers, in accordance with Sections 31A-30-105 and
5483 31A-30-106.1.

5484 (c) The plan adopted under Subsection (2)(a) for the defined contribution arrangement
5485 market shall outline how:

5486 (i) premium contributions for qualified individuals shall be submitted to the Health
5487 Insurance Exchange in the amount determined under Subsection (2)(b); and

5488 (ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by
5489 qualified individuals within an employer group based on each individual's rating factor
5490 determined in accordance with the plan.

5491 (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting
5492 risk between defined contribution arrangement market insurers that:

5493 (i) identifies health care conditions subject to risk adjustment;

5494 (ii) establishes an adjustment amount for each identified health care condition;

5495 (iii) determines the extent to which an insurer has more or less individuals with an
5496 identified health condition than would be expected; and

5497 (iv) computes all risk adjustments.

5498 (e) The board may amend the plan if necessary to:

5499 (i) maintain the proper functioning and solvency of the defined contribution
5500 arrangement market and the risk adjuster mechanism;

5501 (ii) mitigate significant issues of risk selection; or

5502 (iii) improve the administration of the risk adjuster mechanism.

5503 (3) The board shall establish a mechanism in which the defined contribution
5504 arrangement market participating carriers shall submit their plan base rates, rating factors, and
5505 premiums to the commissioner for an actuarial review under ~~[the provisions of]~~ Section
5506 31A-30-115 ~~[prior to]~~ before the publication of the premium rates on the Health Insurance
5507 Exchange.

5508 Section 61. Section 31A-43-102 is amended to read:

5509 **31A-43-102. Definitions.**

5510 For purposes of this chapter:

5511 (1) "Actuarial certification" means a written statement by a member of the American
5512 Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer

5513 is in compliance with ~~[the provisions of]~~ this chapter, based upon the individual's examination
5514 and including a review of the appropriate records and the actuarial assumptions and methods
5515 used by the stop-loss insurer in establishing attachment points and other applicable
5516 determinations in conjunction with the provision of stop-loss insurance coverage.

5517 (2) "Aggregate attachment point" means the dollar amount ~~[in losses for eligible~~
5518 ~~expenses]~~ of covered claims incurred by a small employer plan beyond which the stop-loss
5519 insurer incurs liability for ~~[all or part of the]~~ losses incurred by the small employer plan, subject
5520 to limitations included in the contract.

5521 (3) "Coverage" means the combination of the employer plan design and the stop-loss
5522 contract design.

5523 (4) "Expected claims" means the amount of claims that, in the absence of ~~[a]~~ aggregate
5524 stop-loss ~~[contract]~~ insurance, are projected to be incurred by a small employer health plan
5525 using reasonable and accepted actuarial principles.

5526 (5) "Lasering":

5527 (a) means increasing or removing stop-loss coverage for a specific individual within an
5528 employer group; and

5529 (b) includes other practices that are prohibited by the commissioner by administrative
5530 rule that result in lowering the stop-loss premium for the employer by transferring the risk for
5531 an ~~[individual]~~ individual's claims back to the employer.

5532 (6) "Small employer" means an employer who, with respect to a calendar year and to a
5533 plan year:

5534 (a) employed an average of at least two employees but not more than 50 eligible
5535 employees on each business day during the preceding calendar year; and

5536 (b) employs at least two employees on the first day of the plan year.

5537 (7) "Specific attachment point" means the dollar amount ~~[in losses for eligible~~
5538 ~~expenses]~~ of covered claims attributable to a single individual covered by a small employer
5539 plan in a contract year beyond which the stop-loss insurer assumes ~~[all or part of]~~ the liability
5540 for losses incurred by the small employer plan, subject to limitations included in the contract.

5541 (8) "Stop-loss insurance" means insurance purchased by a small employer for which
5542 the stop-loss insurer assumes~~[, on a per-loss basis,]~~ all loss amounts of the small employer's
5543 plan in excess of a stated amount, subject to the policy limit.

5544 Section 62. Section 31A-43-301 is amended to read:

5545 **31A-43-301. Stop-loss insurance coverage standards.**

5546 (1) A small employer stop-loss insurance contract shall:

5547 (a) be issued to the small employer to provide insurance to the group health benefit
5548 plan, not the employees of the small employer;

5549 (b) use a standard application form developed by the commissioner by administrative
5550 rule;

5551 (c) have a contract term with guaranteed rates for at least 12 months, without
5552 adjustment, unless there is a change in the benefits provided under the small employer's health
5553 plan during the contract period;

5554 (d) include both a specific attachment point and an aggregate attachment point in a
5555 contract;

5556 (e) align stop-loss plan benefit limitations and exclusions with a small employer's
5557 health plan benefit limitations and exclusions, including any annual or lifetime limits in the
5558 employer's health plan;

5559 (f) have an annual specific attachment point that is at least \$10,000;

5560 (g) have an annual aggregate attachment point that may not be less than [90%] 85% of
5561 expected claims;

5562 (h) pay stop-loss claims:

5563 (i) incurred during the contract period; and

5564 (ii) [~~submitted~~] paid within 12 months after the expiration date of the contract; and

5565 (i) include provisions to cover incurred and unpaid claims if a small employer plan
5566 terminates.

5567 (2) A small employer stop-loss contract shall not:

5568 (a) include lasering; and

5569 (b) pay claims directly to an individual employee, member, or participant.

5570 Section 63. Section 31A-43-302 is amended to read:

5571 **31A-43-302. Stop-loss restrictions -- Filing requirements.**

5572 [~~(1) A stop-loss insurer shall demonstrate to the commissioner that the rates associated~~
5573 ~~with specific and aggregate attachment points retained by a small employer group under the~~
5574 ~~insurer's stop-loss plan are actuarially sound.]~~

5575 ~~[(2)]~~ (1) A stop-loss insurer shall file the stop-loss insurance contract form and ~~[rates]~~
 5576 rate methodology with the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1
 5577 before the stop-loss insurance contract may be issued or delivered in the state.

5578 ~~[(3)]~~ (2) A stop-loss insurer shall file with the commissioner, annually on or before
 5579 April 1, in a form and manner required by the commissioner by administrative rule adopted by
 5580 the commissioner:

5581 (a) an actuarial memorandum and certification which demonstrates that the insurer is in
 5582 compliance with this chapter; and

5583 (b) the stop-loss insurer's stop-loss experience.

5584 ~~[(4) Each]~~ (3) An insurer shall maintain at its principal place of business:

5585 (a) a complete and detailed description of its rating practices and renewal underwriting
 5586 practices, including information and documentation that demonstrate the rating methods and
 5587 practices are:

5588 (i) based upon commonly accepted actuarial assumptions; and

5589 (ii) in accordance with sound actuarial principles; and

5590 (b) a copy of the ~~[actuarial certification]~~ annual filing required by Subsection ~~[(3)]~~ (2).

5591 Section 64. Section 31A-43-303 is amended to read:

5592 **31A-43-303. Stop-loss insurance disclosure.**

5593 A stop-loss insurance contract delivered, issued for delivery, or entered into shall
 5594 include the disclosure exhibit required by the commissioner through administrative rule, which
 5595 shall include at least the following information:

5596 (1) the complete costs for the stop-loss contract;

5597 (2) the date on which the insurance takes effect and terminates, including renewability
 5598 provisions;

5599 (3) the aggregate attachment point and the specific attachment point;

5600 (4) ~~[any]~~ limitations on coverage;

5601 (5) an explanation of monthly accommodation and disclosure about any monthly
 5602 accommodation features included in the stop-loss contract; ~~[and]~~

5603 (6) a description of terminal liability funding, including~~[:(a)]~~ the cost of processing
 5604 claims before and after the termination of the contract; and

5605 ~~[(b)]~~ (7) maximum claims liability to the employer.

5606 Section 65. Section 31A-43-304 is amended to read:

5607 **31A-43-304. Administrative rules.**

5608 The commissioner may adopt administrative rules in accordance with Title 63G,
5609 Chapter 3, Utah Administrative Rulemaking Act, to:

5610 (1) implement this chapter;

5611 [~~(2) assure that differences in rates charged are reasonable and reflect objective~~
5612 ~~differences in plan design;~~]

5613 [~~(3)~~] (2) define lasering practices that are prohibited by this chapter;

5614 [~~(4)~~] (3) establish the form and manner of the actuarial certification and the annual
5615 report on stop-loss experience required by Section 31A-43-302;

5616 [~~(5)~~] (4) establish the form and manner of the disclosure required by Section
5617 31A-43-303;

5618 [~~(6)~~] (5) assure the rates associated with the specific attachment points and aggregate
5619 attachment points are actuarially sound and are not against the public interest; and

5620 [~~(7)~~] (6) assure that stop-loss contracts include provisions to cover incurred and unpaid
5621 claims if a small employer plan terminates.

5622 Section 66. Section 53-13-103 is amended to read:

5623 **53-13-103. Law enforcement officer.**

5624 (1) (a) "Law enforcement officer" means a sworn and certified peace officer who is an
5625 employee of a law enforcement agency that is part of or administered by the state or any of its
5626 political subdivisions, and whose primary and principal duties consist of the prevention and
5627 detection of crime and the enforcement of criminal statutes or ordinances of this state or any of
5628 its political subdivisions.

5629 (b) "Law enforcement officer" specifically includes the following:

5630 (i) any sheriff or deputy sheriff, chief of police, police officer, or marshal of any
5631 county, city, or town;

5632 (ii) the commissioner of public safety and any member of the Department of Public
5633 Safety certified as a peace officer;

5634 (iii) all persons specified in Sections 23-20-1.5 and 79-4-501;

5635 (iv) any police officer employed by any college or university;

5636 (v) investigators for the Motor Vehicle Enforcement Division;

- 5637 (vi) investigators for the Department of Insurance, Fraud Division;
5638 [~~(vi)~~] (vii) special agents or investigators employed by the attorney general, district
5639 attorneys, and county attorneys;
5640 [~~(vii)~~] (viii) employees of the Department of Natural Resources designated as peace
5641 officers by law;
5642 [~~(viii)~~] (ix) school district police officers as designated by the board of education for
5643 the school district;
5644 [~~(ix)~~] (x) the executive director of the Department of Corrections and any correctional
5645 enforcement or investigative officer designated by the executive director and approved by the
5646 commissioner of public safety and certified by the division;
5647 [~~(x)~~] (xi) correctional enforcement, investigative, or adult probation and parole officers
5648 employed by the Department of Corrections serving on or before July 1, 1993;
5649 [~~(xi)~~] (xii) members of a law enforcement agency established by a private college or
5650 university provided that the college or university has been certified by the commissioner of
5651 public safety according to rules of the Department of Public Safety;
5652 [~~(xii)~~] (xiii) airport police officers of any airport owned or operated by the state or any
5653 of its political subdivisions; and
5654 [~~(xiii)~~] (xiv) transit police officers designated under Section [17B-2a-823](#).
5655 (2) Law enforcement officers may serve criminal process and arrest violators of any
5656 law of this state and have the right to require aid in executing their lawful duties.
5657 (3) (a) A law enforcement officer has statewide full-spectrum peace officer authority,
5658 but the authority extends to other counties, cities, or towns only when the officer is acting
5659 under Title 77, Chapter 9, Uniform Act on Fresh Pursuit, unless the law enforcement officer is
5660 employed by the state.
5661 (b) (i) A local law enforcement agency may limit the jurisdiction in which its law
5662 enforcement officers may exercise their peace officer authority to a certain geographic area.
5663 (ii) Notwithstanding Subsection (3)(b)(i), a law enforcement officer may exercise
5664 authority outside of the limited geographic area, pursuant to Title 77, Chapter 9, Uniform Act
5665 on Fresh Pursuit, if the officer is pursuing an offender for an offense that occurred within the
5666 limited geographic area.
5667 (c) The authority of law enforcement officers employed by the Department of

5668 Corrections is regulated by Title 64, Chapter 13, Department of Corrections - State Prison.

5669 (4) A law enforcement officer shall, prior to exercising peace officer authority:

5670 (a) (i) have satisfactorily completed the requirements of Section 53-6-205; or

5671 (ii) have met the waiver requirements in Section 53-6-206; and

5672 (b) have satisfactorily completed annual certified training of at least 40 hours per year
5673 as directed by the director of the division, with the advice and consent of the council.

5674 Section 67. Section 63J-1-602.2 is amended to read:

5675 **63J-1-602.2. List of nonlapsing funds and accounts -- Title 31 through Title 45.**

5676 (1) Appropriations from the Insurance Department Restricted Account created in
5677 Section 31A-3-103, except to the extent that Section 31A-3-103 makes the money received
5678 under that section free revenue.

5679 [~~1~~] (2) Appropriations from the Technology Development Restricted Account created
5680 in Section 31A-3-104.

5681 [~~2~~] (3) Appropriations from the Criminal Background Check Restricted Account
5682 created in Section 31A-3-105.

5683 [~~3~~] (4) Appropriations from the Captive Insurance Restricted Account created in
5684 Section 31A-3-304, except to the extent that Section 31A-3-304 makes the money received
5685 under that section free revenue.

5686 [~~4~~] (5) Appropriations from the Title Licensee Enforcement Restricted Account
5687 created in Section 31A-23a-415.

5688 [~~5~~] (6) Appropriations from the Health Insurance Actuarial Review Restricted
5689 Account created in Section 31A-30-115.

5690 [~~6~~] (7) Appropriations from the Insurance Fraud Investigation Restricted Account
5691 created in Section 31A-31-108.

5692 [~~7~~] (8) Appropriations from the Underage Drinking Prevention Media and Education
5693 Campaign Restricted Account created in Section 32B-2-306.

5694 [~~8~~] (9) The Youth Development Organization Restricted Account created in Section
5695 35A-8-1903.

5696 [~~9~~] (10) The Youth Character Organization Restricted Account created in Section
5697 35A-8-2003.

5698 [~~10~~] (11) Funding for a new program or agency that is designated as nonlapsing under

5699 Section [36-24-101](#).

5700 [~~(11)~~] [\(12\)](#) Appropriations from the Oil and Gas Conservation Account created in

5701 Section [40-6-14.5](#).

5702 [~~(12)~~] [\(13\)](#) Appropriations from the Electronic Payment Fee Restricted Account

5703 created by Section [41-1a-121](#) to the Motor Vehicle Division.

5704 [~~(13)~~] [\(14\)](#) Funds available to the Tax Commission under Section [41-1a-1201](#) for the:

5705 (a) purchase and distribution of license plates and decals; and

5706 (b) administration and enforcement of motor vehicle registration requirements.

5707 Section 68. **Repealer.**

5708 This bill repeals:

5709 Section [31A-30-110](#), **Individual enrollment cap.**

5710 Section [31A-30-111](#), **Limitations on high risk enrollees.**

5711 Section 69. **Effective date.**

5712 This bill takes effect on May 13, 2014, except that the amendments to Section

5713 [31A-3-304](#) (Effective 07/01/15) take effect on July 1, 2015.