

Senator Wayne A. Harper proposes the following substitute bill:

INSURANCE RELATED REVISIONS

2014 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Jim Bird

Senate Sponsor: Wayne A. Harper

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;
- ▶ provides for insurance fraud investigators being designated as law enforcement officers;
- ▶ 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 uninsured and underinsured motorist coverage;
- ▶ 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



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

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

74 **Money Appropriated in this Bill:**

75 None

76 **Other Special Clauses:**

77 This bill provides an effective date.

78 This bill coordinates with H.B. 141, Health Reform Amendments, by providing
79 superseding and substantive amendments.

80 This bill provides revisor instructions.

81 **Utah Code Sections Affected:**

82 AMENDS:

83 **31A-1-301**, as last amended by Laws of Utah 2013, Chapter 319

84 **31A-2-104**, as last amended by Laws of Utah 1999, Chapter 21

85 **31A-3-304 (Superseded 07/01/15)**, as last amended by Laws of Utah 2011, Chapter

86 284

87 **31A-3-304 (Effective 07/01/15)**, as last amended by Laws of Utah 2013, Chapter 319

- 88 [31A-4-102](#), as last amended by Laws of Utah 2008, Chapter 345
- 89 [31A-4-115](#), as last amended by Laws of Utah 2002, Chapter 308
- 90 [31A-8-402.3](#), as last amended by Laws of Utah 2004, Chapter 329
- 91 [31A-16-103](#), as last amended by Laws of Utah 2004, Chapter 2
- 92 [31A-17-607](#), as last amended by Laws of Utah 2001, Chapter 116
- 93 [31A-22-305](#), as last amended by Laws of Utah 2013, Chapter 460
- 94 [31A-22-305.3](#), as last amended by Laws of Utah 2013, Chapter 460
- 95 [31A-22-428](#), as enacted by Laws of Utah 2008, Chapter 345
- 96 [31A-22-617](#), as last amended by Laws of Utah 2013, Chapters 104 and 319
- 97 [31A-22-618.5](#), as last amended by Laws of Utah 2013, Chapter 319
- 98 [31A-22-625](#), as last amended by Laws of Utah 2012, Chapter 253
- 99 [31A-22-635](#), as last amended by Laws of Utah 2012, Chapters 253 and 279
- 100 [31A-22-721](#), as last amended by Laws of Utah 2011, Chapter 284
- 101 [31A-23a-102](#), as last amended by Laws of Utah 2013, Chapter 319
- 102 [31A-23a-104](#), as last amended by Laws of Utah 2012, Chapter 253
- 103 [31A-23a-105](#), as last amended by Laws of Utah 2013, Chapter 319
- 104 [31A-23a-108](#), as last amended by Laws of Utah 2012, Chapter 253
- 105 [31A-23a-112](#), as last amended by Laws of Utah 2008, Chapter 382
- 106 [31A-23a-113](#), as last amended by Laws of Utah 2012, Chapter 253
- 107 [31A-23a-202](#), as last amended by Laws of Utah 2013, Chapter 319
- 108 [31A-23a-203](#), as last amended by Laws of Utah 2012, Chapter 253
- 109 [31A-23a-402.5](#), as last amended by Laws of Utah 2013, Chapter 319
- 110 [31A-23a-501](#), as last amended by Laws of Utah 2013, Chapter 341
- 111 [31A-23b-102](#), as enacted by Laws of Utah 2013, Chapter 341
- 112 [31A-23b-202](#), as enacted by Laws of Utah 2013, Chapter 341
- 113 [31A-23b-205](#), as enacted by Laws of Utah 2013, Chapter 341
- 114 [31A-23b-206](#), as enacted by Laws of Utah 2013, Chapter 341
- 115 [31A-23b-301](#), as enacted by Laws of Utah 2013, Chapter 341
- 116 [31A-23b-402](#), as enacted by Laws of Utah 2013, Chapter 341
- 117 [31A-25-208](#), as last amended by Laws of Utah 2011, Chapter 284
- 118 [31A-25-209](#), as last amended by Laws of Utah 2008, Chapter 382

119 **31A-26-102**, as last amended by Laws of Utah 2012, Chapter 151
120 **31A-26-206**, as last amended by Laws of Utah 2011, Chapter 284
121 **31A-26-207**, as last amended by Laws of Utah 2001, Chapter 116
122 **31A-26-213**, as last amended by Laws of Utah 2011, Chapter 284
123 **31A-26-214**, as last amended by Laws of Utah 2008, Chapter 382
124 **31A-26-214.5**, as last amended by Laws of Utah 2009, Chapter 349
125 **31A-27a-102**, as last amended by Laws of Utah 2008, Chapter 382
126 **31A-27a-107**, as enacted by Laws of Utah 2007, Chapter 309
127 **31A-27a-201**, as enacted by Laws of Utah 2007, Chapter 309
128 **31A-27a-701**, as last amended by Laws of Utah 2011, Chapter 297
129 **31A-29-106**, as last amended by Laws of Utah 2013, Chapter 319
130 **31A-29-111**, as last amended by Laws of Utah 2012, Chapters 158 and 347
131 **31A-29-115**, as last amended by Laws of Utah 2004, Chapter 2
132 **31A-30-102**, as last amended by Laws of Utah 2009, Chapter 12
133 **31A-30-103**, as last amended by Laws of Utah 2013, Chapter 168
134 **31A-30-104**, as last amended by Laws of Utah 2013, Chapters 168 and 341
135 **31A-30-106**, as last amended by Laws of Utah 2011, Chapter 284
136 **31A-30-106.7**, as last amended by Laws of Utah 2008, Chapter 382
137 **31A-30-107**, as last amended by Laws of Utah 2009, Chapter 12
138 **31A-30-108**, as last amended by Laws of Utah 2011, Chapter 284
139 **31A-30-207**, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5
140 **31A-30-209**, as last amended by Laws of Utah 2011, Chapter 400
141 **31A-30-211**, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5
142 **31A-37-501**, as last amended by Laws of Utah 2008, Chapter 302
143 **31A-40-203**, as enacted by Laws of Utah 2008, Chapter 318
144 **31A-40-209**, as enacted by Laws of Utah 2008, Chapter 318
145 **31A-42-202**, as last amended by Laws of Utah 2011, Chapter 400
146 **31A-43-102**, as enacted by Laws of Utah 2013, Chapter 341
147 **31A-43-301**, as enacted by Laws of Utah 2013, Chapter 341
148 **31A-43-302**, as enacted by Laws of Utah 2013, Chapter 341
149 **31A-43-303**, as enacted by Laws of Utah 2013, Chapter 341

150 31A-43-304, as enacted by Laws of Utah 2013, Chapter 341

151 53-13-103, as last amended by Laws of Utah 2011, Chapter 58

152 REPEALS:

153 31A-30-110, as last amended by Laws of Utah 2011, Chapters 284 and 297

154 31A-30-111, as last amended by Laws of Utah 2002, Chapter 308

155 **Utah Code Sections Affected by Coordination Clause:**

156 31A-23b-205, as enacted by Laws of Utah 2013, Chapter 341

157 31A-23b-206, as enacted by Laws of Utah 2013, Chapter 341

158 **Utah Code Sections Affected by Revisor Instructions:**

159 31A-22-305, as last amended by Laws of Utah 2013, Chapter 460

160 31A-22-305.3, as last amended by Laws of Utah 2013, Chapter 460

161

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

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

164 **31A-1-301. Definitions.**

165 As used in this title, unless otherwise specified:

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

168 (i) a medical condition including:

169 (A) a medical care expense; or

170 (B) the risk of disability;

171 (ii) accident; or

172 (iii) sickness.

173 (b) "Accident and health insurance":

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

175 (A) an income replacement contract;

176 (B) a health care contract;

177 (C) an expense reimbursement contract;

178 (D) a credit accident and health contract;

179 (E) a continuing care contract; and

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

- 181 (ii) may provide:
- 182 (A) hospital coverage;
- 183 (B) surgical coverage;
- 184 (C) medical coverage;
- 185 (D) loss of income coverage;
- 186 (E) prescription drug coverage;
- 187 (F) dental coverage; or
- 188 (G) vision coverage.
- 189 (c) "Accident and health insurance" does not include workers' compensation insurance.
- 190 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
- 191 63G, Chapter 3, Utah Administrative Rulemaking Act.
- 192 (3) "Administrator" is defined in Subsection [~~(163)~~] (164).
- 193 (4) "Adult" means an individual who has attained the age of at least 18 years.
- 194 (5) "Affiliate" means a person who controls, is controlled by, or is under common
- 195 control with, another person. A corporation is an affiliate of another corporation, regardless of
- 196 ownership, if substantially the same group of individuals manage the corporations.
- 197 (6) "Agency" means:
- 198 (a) a person other than an individual, including a sole proprietorship by which an
- 199 individual does business under an assumed name; and
- 200 (b) an insurance organization licensed or required to be licensed under Section
- 201 [31A-23a-301](#), [31A-25-207](#), or [31A-26-209](#).
- 202 (7) "Alien insurer" means an insurer domiciled outside the United States.
- 203 (8) "Amendment" means an endorsement to an insurance policy or certificate.
- 204 (9) "Annuity" means an agreement to make periodical payments for a period certain or
- 205 over the lifetime of one or more individuals if the making or continuance of all or some of the
- 206 series of the payments, or the amount of the payment, is dependent upon the continuance of
- 207 human life.
- 208 (10) "Application" means a document:
- 209 (a) (i) completed by an applicant to provide information about the risk to be insured;
- 210 and
- 211 (ii) that contains information that is used by the insurer to evaluate risk and decide

212 whether to:

213 (A) insure the risk under:

214 (I) the coverage as originally offered; or

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

216 (B) decline to insure the risk; or

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

218 annuity contract.

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

220 (a) the original articles;

221 (b) a special law;

222 (c) a charter;

223 (d) an amendment;

224 (e) restated articles;

225 (f) articles of merger or consolidation;

226 (g) a trust instrument;

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

228 and

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

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

233 (13) "Binder" is defined in Section [31A-21-102](#).

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

236 (a) without individual underwriting or application; and

237 (b) that is determined by definition without designating each person covered.

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

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

241 (a) that is open to the public;

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

- 243 (c) at which the public may appear in person to obtain services.
- 244 (17) "Business entity" means:
- 245 (a) a corporation;
- 246 (b) an association;
- 247 (c) a partnership;
- 248 (d) a limited liability company;
- 249 (e) a limited liability partnership; or
- 250 (f) another legal entity.
- 251 (18) "Business of insurance" is defined in Subsection (88).
- 252 (19) "Business plan" means the information required to be supplied to the
- 253 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
- 254 when these subsections apply by reference under:
- 255 (a) Section 31A-7-201;
- 256 (b) Section 31A-8-205; or
- 257 (c) Subsection 31A-9-205(2).
- 258 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
- 259 corporation's affairs, however designated.
- 260 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a
- 261 corporation.
- 262 (21) "Captive insurance company" means:
- 263 (a) an insurer:
- 264 (i) owned by another organization; and
- 265 (ii) whose exclusive purpose is to insure risks of the parent organization and an
- 266 affiliated company; or
- 267 (b) in the case of a group or association, an insurer:
- 268 (i) owned by the insureds; and
- 269 (ii) whose exclusive purpose is to insure risks of:
- 270 (A) a member organization;
- 271 (B) a group member; or
- 272 (C) an affiliate of:
- 273 (I) a member organization; or

- 274 (II) a group member.
- 275 (22) "Casualty insurance" means liability insurance.
- 276 (23) "Certificate" means evidence of insurance given to:
- 277 (a) an insured under a group insurance policy; or
- 278 (b) a third party.
- 279 (24) "Certificate of authority" is included within the term "license."
- 280 (25) "Claim," unless the context otherwise requires, means a request or demand on an
- 281 insurer for payment of a benefit according to the terms of an insurance policy.
- 282 (26) "Claims-made coverage" means an insurance contract or provision limiting
- 283 coverage under a policy insuring against legal liability to claims that are first made against the
- 284 insured while the policy is in force.
- 285 (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
- 286 commissioner.
- 287 (b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent
- 288 supervisory official of another jurisdiction.
- 289 (28) (a) "Continuing care insurance" means insurance that:
- 290 (i) provides board and lodging;
- 291 (ii) provides one or more of the following:
- 292 (A) a personal service;
- 293 (B) a nursing service;
- 294 (C) a medical service; or
- 295 (D) any other health-related service; and
- 296 (iii) provides the coverage described in this Subsection (28)(a) under an agreement
- 297 effective:
- 298 (A) for the life of the insured; or
- 299 (B) for a period in excess of one year.
- 300 (b) Insurance is continuing care insurance regardless of whether or not the board and
- 301 lodging are provided at the same location as a service described in Subsection (28)(a)(ii).
- 302 (29) (a) "Control," "controlling," "controlled," or "under common control" means the
- 303 direct or indirect possession of the power to direct or cause the direction of the management
- 304 and policies of a person. This control may be:

- 305 (i) by contract;
- 306 (ii) by common management;
- 307 (iii) through the ownership of voting securities; or
- 308 (iv) by a means other than those described in Subsections (29)(a)(i) through (iii).
- 309 (b) There is no presumption that an individual holding an official position with another
- 310 person controls that person solely by reason of the position.
- 311 (c) A person having a contract or arrangement giving control is considered to have
- 312 control despite the illegality or invalidity of the contract or arrangement.
- 313 (d) There is a rebuttable presumption of control in a person who directly or indirectly
- 314 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the
- 315 voting securities of another person.
- 316 (30) "Controlled insurer" means a licensed insurer that is either directly or indirectly
- 317 controlled by a producer.
- 318 (31) "Controlling person" means a person that directly or indirectly has the power to
- 319 direct or cause to be directed, the management, control, or activities of a reinsurance
- 320 intermediary.
- 321 (32) "Controlling producer" means a producer who directly or indirectly controls an
- 322 insurer.
- 323 (33) (a) "Corporation" means an insurance corporation, except when referring to:
- 324 (i) a corporation doing business:
- 325 (A) as:
- 326 (I) an insurance producer;
- 327 (II) a surplus lines producer;
- 328 (III) a limited line producer;
- 329 (IV) a consultant;
- 330 (V) a managing general agent;
- 331 (VI) a reinsurance intermediary;
- 332 (VII) a third party administrator; or
- 333 (VIII) an adjuster; and
- 334 (B) under:
- 335 (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and

336 Reinsurance Intermediaries;

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

338 (III) Chapter 26, Insurance Adjusters; or

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

340 Holding Companies.

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

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

343 (34) (a) "Creditable coverage" has the same meaning as provided in federal regulations

344 adopted pursuant to the Health Insurance Portability and Accountability Act.

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

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

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

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

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

351 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. 109-415.

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

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

357 (b) "Credit insurance" includes:

358 (i) credit accident and health insurance;

359 (ii) credit life insurance;

360 (iii) credit property insurance;

361 (iv) credit unemployment insurance;

362 (v) guaranteed automobile protection insurance;

363 (vi) involuntary unemployment insurance;

364 (vii) mortgage accident and health insurance;

365 (viii) mortgage guaranty insurance; and

366 (ix) mortgage life insurance.

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

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

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

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

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

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

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

375 (i) specific loan; or

376 (ii) credit transaction.

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

378 (a) matured;

379 (b) unmatured;

380 (c) liquidated;

381 (d) unliquidated;

382 (e) secured;

383 (f) unsecured;

384 (g) absolute;

385 (h) fixed; or

386 (i) contingent.

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

390 (i) provided by the private insurance market; or

391 (ii) subsidized by the Federal Crop Insurance Corporation.

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

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

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

396 (A) producer;

397 (B) surplus lines producer; or

- 398 (C) consultant employer; and
- 399 (ii) to the customer service representative's employer's:
- 400 (A) customer;
- 401 (B) client; or
- 402 (C) organization.
- 403 (b) A customer service representative may only operate within the scope of authority of
- 404 the customer service representative's producer, surplus lines producer, or consultant employer.
- 405 (43) "Deadline" means a final date or time:
- 406 (a) imposed by:
- 407 (i) statute;
- 408 (ii) rule; or
- 409 (iii) order; and
- 410 (b) by which a required filing or payment must be received by the department.
- 411 (44) "Deemer clause" means a provision under this title under which upon the
- 412 occurrence of a condition precedent, the commissioner is considered to have taken a specific
- 413 action. If the statute so provides, a condition precedent may be the commissioner's failure to
- 414 take a specific action.
- 415 (45) "Degree of relationship" means the number of steps between two persons
- 416 determined by counting the generations separating one person from a common ancestor and
- 417 then counting the generations to the other person.
- 418 (46) "Department" means the Insurance Department.
- 419 (47) "Director" means a member of the board of directors of a corporation.
- 420 (48) "Disability" means a physiological or psychological condition that partially or
- 421 totally limits an individual's ability to:
- 422 (a) perform the duties of:
- 423 (i) that individual's occupation; or
- 424 (ii) [~~any~~] an occupation for which the individual is reasonably suited by education,
- 425 training, or experience; or
- 426 (b) perform two or more of the following basic activities of daily living:
- 427 (i) eating;
- 428 (ii) toileting;

- 429 (iii) transferring;
- 430 (iv) bathing; or
- 431 (v) dressing.
- 432 (49) "Disability income insurance" is defined in Subsection (79).
- 433 (50) "Domestic insurer" means an insurer organized under the laws of this state.
- 434 (51) "Domiciliary state" means the state in which an insurer:
- 435 (a) is incorporated;
- 436 (b) is organized; or
- 437 (c) in the case of an alien insurer, enters into the United States.
- 438 (52) (a) "Eligible employee" means:
- 439 (i) an employee who:
- 440 (A) works on a full-time basis; and
- 441 (B) has a normal work week of 30 or more hours; or
- 442 (ii) a person described in Subsection (52)(b).
- 443 (b) "Eligible employee" includes, if the individual is included under a health benefit
- 444 plan of a small employer:
- 445 (i) a sole proprietor;
- 446 (ii) a partner in a partnership; or
- 447 (iii) an independent contractor.
- 448 (c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):
- 449 (i) an individual who works on a temporary or substitute basis for a small employer;
- 450 (ii) an employer's spouse; or
- 451 (iii) a dependent of an employer.
- 452 (53) "Employee" means an individual employed by an employer.
- 453 (54) "Employee benefits" means one or more benefits or services provided to:
- 454 (a) an employee; or
- 455 (b) a dependent of an employee.
- 456 (55) (a) "Employee welfare fund" means a fund:
- 457 (i) established or maintained, whether directly or through a trustee, by:
- 458 (A) one or more employers;
- 459 (B) one or more labor organizations; or

- 460 (C) a combination of employers and labor organizations; and
461 (ii) that provides employee benefits paid or contracted to be paid, other than income
462 from investments of the fund:
- 463 (A) by or on behalf of an employer doing business in this state; or
464 (B) for the benefit of a person employed in this state.
- 465 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax
466 revenues.
- 467 (56) "Endorsement" means a written agreement attached to a policy or certificate to
468 modify the policy or certificate coverage.
- 469 (57) "Enrollment date," with respect to a health benefit plan, means:
470 (a) the first day of coverage; or
471 (b) if there is a waiting period, the first day of the waiting period.
- 472 (58) (a) "Escrow" means:
473 (i) a transaction that effects the sale, transfer, encumbering, or leasing of real property,
474 when a person not a party to the transaction, and neither having nor acquiring an interest in the
475 title, performs, in accordance with the written instructions or terms of the written agreement
476 between the parties to the transaction, any of the following actions:
477 (A) the explanation, holding, or creation of a document; or
478 (B) the receipt, deposit, and disbursement of money;
479 (ii) a settlement or closing involving:
480 (A) a mobile home;
481 (B) a grazing right;
482 (C) a water right; or
483 (D) other personal property authorized by the commissioner.
- 484 (b) "Escrow" does not include:
485 (i) the following notarial acts performed by a notary within the state:
486 (A) an acknowledgment;
487 (B) a copy certification;
488 (C) jurat; and
489 (D) an oath or affirmation;
490 (ii) the receipt or delivery of a document; or

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

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

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

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

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

- 501 (a) a specific physical condition;
- 502 (b) a specific medical procedure;
- 503 (c) a specific disease or disorder; or
- 504 (d) a specific prescription drug or class of prescription drugs.

505 (62) "Expense reimbursement insurance" means insurance:

- 506 (a) written to provide a payment for an expense relating to hospital confinement
507 resulting from illness or injury; and
- 508 (b) written:
 - 509 (i) as a daily limit for a specific number of days in a hospital; and
 - 510 (ii) to have a one or two day waiting period following a hospitalization.

511 (63) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding
512 a position of public or private trust.

513 (64) (a) "Filed" means that a filing is:

- 514 (i) submitted to the department as required by and in accordance with applicable
515 statute, rule, or filing order;
- 516 (ii) received by the department within the time period provided in applicable statute,
517 rule, or filing order; and
- 518 (iii) accompanied by the appropriate fee in accordance with:
 - 519 (A) Section 31A-3-103; or
 - 520 (B) rule.

521 (b) "Filed" does not include a filing that is rejected by the department because it is not

522 submitted in accordance with Subsection (64)(a).

523 (65) "Filing," when used as a noun, means an item required to be filed with the
524 department including:

525 (a) a policy;

526 (b) a rate;

527 (c) a form;

528 (d) a document;

529 (e) a plan;

530 (f) a manual;

531 (g) an application;

532 (h) a report;

533 (i) a certificate;

534 (j) an endorsement;

535 (k) an actuarial certification;

536 (l) a licensee annual statement;

537 (m) a licensee renewal application;

538 (n) an advertisement; or

539 (o) an outline of coverage.

540 (66) "First party insurance" means an insurance policy or contract in which the insurer
541 agrees to pay a claim submitted to it by the insured for the insured's losses.

542 (67) "Foreign insurer" means an insurer domiciled outside of this state, including an
543 alien insurer.

544 (68) (a) "Form" means one of the following prepared for general use:

545 (i) a policy;

546 (ii) a certificate;

547 (iii) an application;

548 (iv) an outline of coverage; or

549 (v) an endorsement.

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

552 (69) "Franchise insurance" means an individual insurance policy provided through a

553 mass marketing arrangement involving a defined class of persons related in some way other
554 than through the purchase of insurance.

555 (70) "General lines of authority" include:

556 (a) the general lines of insurance in Subsection (71);

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

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

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

560 (iii) title marketing representative only;

561 (c) surplus lines;

562 (d) workers' compensation; and

563 (e) [~~any other~~] another line of insurance that the commissioner considers necessary to
564 recognize in the public interest.

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

566 (a) accident and health;

567 (b) casualty;

568 (c) life;

569 (d) personal lines;

570 (e) property; and

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

572 (72) "Group health plan" means an employee welfare benefit plan to the extent that the
573 plan provides medical care:

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

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

576 (b) (i) directly;

577 (ii) through insurance reimbursement; or

578 (iii) through another method.

579 (73) (a) "Group insurance policy" means a policy covering a group of persons that is
580 issued:

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

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

583 in:

584 (A) the policy; or

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

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

588 (74) "Guaranteed automobile protection insurance" means insurance offered in
589 connection with an extension of credit that pays the difference in amount between the
590 insurance settlement and the balance of the loan if the insured automobile is a total loss.

591 (75) (a) Except as provided in Subsection (75)(b), "health benefit plan" means a policy
592 or certificate that:

593 (i) provides health care insurance;

594 (ii) provides major medical expense insurance; or

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

596 (A) a hospital confinement indemnity; or

597 (B) a limited benefit plan.

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

599 (i) provides benefits solely for:

600 (A) accident;

601 (B) dental;

602 (C) income replacement;

603 (D) long-term care;

604 (E) a Medicare supplement;

605 (F) a specified disease;

606 (G) vision; or

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

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

609 (76) "Health care" means any of the following intended for use in the diagnosis,
610 treatment, mitigation, or prevention of a human ailment or impairment:

611 (a) a professional service;

612 (b) a personal service;

613 (c) a facility;

614 (d) equipment;

- 615 (e) a device;
- 616 (f) supplies; or
- 617 (g) medicine.
- 618 (77) (a) "Health care insurance" or "health insurance" means insurance providing:
- 619 (i) a health care benefit; or
- 620 (ii) payment of an incurred health care expense.
- 621 (b) "Health care insurance" or "health insurance" does not include accident and health
- 622 insurance providing a benefit for:
- 623 (i) replacement of income;
- 624 (ii) short-term accident;
- 625 (iii) fixed indemnity;
- 626 (iv) credit accident and health;
- 627 (v) supplements to liability;
- 628 (vi) workers' compensation;
- 629 (vii) automobile medical payment;
- 630 (viii) no-fault automobile;
- 631 (ix) equivalent self-insurance; or
- 632 (x) a type of accident and health insurance coverage that is a part of or attached to
- 633 another type of policy.
- 634 (78) "Health Insurance Portability and Accountability Act" means the Health Insurance
- 635 Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended.
- 636 (79) "Income replacement insurance" or "disability income insurance" means insurance
- 637 written to provide payments to replace income lost from accident or sickness.
- 638 (80) "Indemnity" means the payment of an amount to offset all or part of an insured
- 639 loss.
- 640 (81) "Independent adjuster" means an insurance adjuster required to be licensed under
- 641 Section [31A-26-201](#) who engages in insurance adjusting as a representative of an insurer.
- 642 (82) "Independently procured insurance" means insurance procured under Section
- 643 [31A-15-104](#).
- 644 (83) "Individual" means a natural person.
- 645 (84) "Inland marine insurance" includes insurance covering:

- 646 (a) property in transit on or over land;
 - 647 (b) property in transit over water by means other than boat or ship;
 - 648 (c) bailee liability;
 - 649 (d) fixed transportation property such as bridges, electric transmission systems, radio
 - 650 and television transmission towers and tunnels; and
 - 651 (e) personal and commercial property floaters.
- 652 (85) "Insolvency" means that:
- 653 (a) an insurer is unable to pay its debts or meet its obligations as the debts and
 - 654 obligations mature;
 - 655 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
 - 656 RBC under Subsection 31A-17-601(8)(c); or
 - 657 (c) an insurer is determined to be hazardous under this title.
- 658 (86) (a) "Insurance" means:
- 659 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
 - 660 persons to one or more other persons; or
 - 661 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
 - 662 group of persons that includes the person seeking to distribute that person's risk.
- 663 (b) "Insurance" includes:
- 664 (i) a risk distributing arrangement providing for compensation or replacement for
 - 665 damages or loss through the provision of a service or a benefit in kind;
 - 666 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a
 - 667 business and not as merely incidental to a business transaction; and
 - 668 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,
 - 669 but with a class of persons who have agreed to share the risk.
- 670 (87) "Insurance adjuster" means a person who directs or conducts the investigation,
- 671 negotiation, or settlement of a claim under an insurance policy other than life insurance or an
- 672 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.
- 673 (88) "Insurance business" or "business of insurance" includes:
- 674 (a) providing health care insurance by an organization that is or is required to be
 - 675 licensed under this title;
 - 676 (b) providing a benefit to an employee in the event of a contingency not within the

677 control of the employee, in which the employee is entitled to the benefit as a right, which
678 benefit may be provided either:

- 679 (i) by a single employer or by multiple employer groups; or
- 680 (ii) through one or more trusts, associations, or other entities;
- 681 (c) providing an annuity:
 - 682 (i) including an annuity issued in return for a gift; and
 - 683 (ii) except an annuity provided by a person specified in Subsections [31A-22-1305\(2\)](#)

684 and (3);

- 685 (d) providing the characteristic services of a motor club as outlined in Subsection
- 686 (116);
- 687 (e) providing another person with insurance;
- 688 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,
- 689 or surety, a contract or policy of title insurance;
- 690 (g) transacting or proposing to transact any phase of title insurance, including:
 - 691 (i) solicitation;
 - 692 (ii) negotiation preliminary to execution;
 - 693 (iii) execution of a contract of title insurance;
 - 694 (iv) insuring; and
 - 695 (v) transacting matters subsequent to the execution of the contract and arising out of
 - 696 the contract, including reinsurance;
 - 697 (h) transacting or proposing a life settlement; and
 - 698 (i) doing, or proposing to do, any business in substance equivalent to Subsections
 - 699 (88)(a) through (h) in a manner designed to evade this title.
- 700 (89) "Insurance consultant" or "consultant" means a person who:
 - 701 (a) advises another person about insurance needs and coverages;
 - 702 (b) is compensated by the person advised on a basis not directly related to the insurance
 - 703 placed; and
 - 704 (c) except as provided in Section [31A-23a-501](#), is not compensated directly or
 - 705 indirectly by an insurer or producer for advice given.
- 706 (90) "Insurance holding company system" means a group of two or more affiliated
- 707 persons, at least one of whom is an insurer.

708 (91) (a) "Insurance producer" or "producer" means a person licensed or required to be
709 licensed under the laws of this state to sell, solicit, or negotiate insurance.

710 (b) (i) "Producer for the insurer" means a producer who is compensated directly or
711 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that
712 insurer.

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

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

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

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

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

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

722 (i) a policyholder;

723 (ii) a subscriber;

724 (iii) a member; and

725 (iv) a beneficiary.

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

727 (i) applies only to this title; and

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

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

731 (i) a fraternal benefit society;

732 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
733 [31A-22-1305\(2\)](#) and (3);

734 (iii) a motor club;

735 (iv) an employee welfare plan; and

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

738 (b) "Insurer" does not include a governmental entity to the extent the governmental

739 entity is engaged in an activity described in Section 31A-12-107.

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

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

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

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

745 (i) specific loan; or

746 (ii) credit transaction.

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

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

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

752 (97) "Late enrollee," with respect to an employer health benefit plan, means an
753 individual whose enrollment is a late enrollment.

754 (98) "Late enrollment," with respect to an employer health benefit plan, means
755 enrollment of an individual other than:

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

758 (b) through special enrollment.

759 (99) (a) Except for a retainer contract or legal assistance described in Section
760 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a
761 specified legal expense.

762 (b) "Legal expense insurance" includes an arrangement that creates a reasonable
763 expectation of an enforceable right.

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

766 (100) (a) "Liability insurance" means insurance against liability:

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

769 (A) Subsection (110) for medical malpractice insurance;

- 770 (B) Subsection (138) for professional liability insurance; and
771 (C) Subsection [~~(172)~~] (173) for workers' compensation insurance;
772 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the
773 insured who is injured, irrespective of legal liability of the insured, when issued with or
774 supplemental to insurance against legal liability for the death, injury, or disability of a human
775 being, exclusive of the coverages under:
- 776 (A) Subsection (110) for medical malpractice insurance;
777 (B) Subsection (138) for professional liability insurance; and
778 (C) Subsection [~~(172)~~] (173) for workers' compensation insurance;
779 (iii) for loss or damage to property resulting from an accident to or explosion of a
780 boiler, pipe, pressure container, machinery, or apparatus;
781 (iv) for loss or damage to property caused by:
782 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
783 (B) water entering through a leak or opening in a building; or
784 (v) for other loss or damage properly the subject of insurance not within another kind
785 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.
- 786 (b) "Liability insurance" includes:
787 (i) vehicle liability insurance;
788 (ii) residential dwelling liability insurance; and
789 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
790 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
791 elevator, boiler, machinery, or apparatus.
- 792 (101) (a) "License" means authorization issued by the commissioner to engage in an
793 activity that is part of or related to the insurance business.
- 794 (b) "License" includes a certificate of authority issued to an insurer.
- 795 (102) (a) "Life insurance" means:
796 (i) insurance on a human life; and
797 (ii) insurance pertaining to or connected with human life.
- 798 (b) The business of life insurance includes:
799 (i) granting a death benefit;
800 (ii) granting an annuity benefit;

- 801 (iii) granting an endowment benefit;
- 802 (iv) granting an additional benefit in the event of death by accident;
- 803 (v) granting an additional benefit to safeguard the policy against lapse; and
- 804 (vi) providing an optional method of settlement of proceeds.
- 805 (103) "Limited license" means a license that:
- 806 (a) is issued for a specific product of insurance; and
- 807 (b) limits an individual or agency to transact only for that product or insurance.
- 808 (104) "Limited line credit insurance" includes the following forms of insurance:
- 809 (a) credit life;
- 810 (b) credit accident and health;
- 811 (c) credit property;
- 812 (d) credit unemployment;
- 813 (e) involuntary unemployment;
- 814 (f) mortgage life;
- 815 (g) mortgage guaranty;
- 816 (h) mortgage accident and health;
- 817 (i) guaranteed automobile protection; and
- 818 (j) another form of insurance offered in connection with an extension of credit that:
- 819 (i) is limited to partially or wholly extinguishing the credit obligation; and
- 820 (ii) the commissioner determines by rule should be designated as a form of limited line
- 821 credit insurance.
- 822 (105) "Limited line credit insurance producer" means a person who sells, solicits, or
- 823 negotiates one or more forms of limited line credit insurance coverage to an individual through
- 824 a master, corporate, group, or individual policy.
- 825 (106) "Limited line insurance" includes:
- 826 (a) bail bond;
- 827 (b) limited line credit insurance;
- 828 (c) legal expense insurance;
- 829 (d) motor club insurance;
- 830 (e) car rental related insurance;
- 831 (f) travel insurance;

- 832 (g) crop insurance;
- 833 (h) self-service storage insurance;
- 834 (i) guaranteed asset protection waiver;
- 835 (j) portable electronics insurance; and
- 836 (k) another form of limited insurance that the commissioner determines by rule should
- 837 be designated a form of limited line insurance.

838 (107) "Limited lines authority" includes~~[(a)]~~ the lines of insurance listed in

839 Subsection (106)~~[, and]~~.

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

841 (108) "Limited lines producer" means a person who sells, solicits, or negotiates limited

842 lines insurance.

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

844 marketed, offered, or designated to provide coverage:

- 845 (i) in a setting other than an acute care unit of a hospital;
- 846 (ii) for not less than 12 consecutive months for a covered person on the basis of:
 - 847 (A) expenses incurred;
 - 848 (B) indemnity;
 - 849 (C) prepayment; or
 - 850 (D) another method;
 - 851 (iii) for one or more necessary or medically necessary services that are:
 - 852 (A) diagnostic;
 - 853 (B) preventative;
 - 854 (C) therapeutic;
 - 855 (D) rehabilitative;
 - 856 (E) maintenance; or
 - 857 (F) personal care; and
 - 858 (iv) that may be issued by:
 - 859 (A) an insurer;
 - 860 (B) a fraternal benefit society;
 - 861 (C) (I) a nonprofit health hospital; and
 - 862 (II) a medical service corporation;

- 863 (D) a prepaid health plan;
- 864 (E) a health maintenance organization; or
- 865 (F) an entity similar to the entities described in Subsections (109)(a)(iv)(A) through (E)
- 866 to the extent that the entity is otherwise authorized to issue life or health care insurance.
- 867 (b) "Long-term care insurance" includes:
- 868 (i) any of the following that provide directly or supplement long-term care insurance:
- 869 (A) a group or individual annuity or rider; or
- 870 (B) a life insurance policy or rider;
- 871 (ii) a policy or rider that provides for payment of benefits on the basis of:
- 872 (A) cognitive impairment; or
- 873 (B) functional capacity; or
- 874 (iii) a qualified long-term care insurance contract.
- 875 (c) "Long-term care insurance" does not include:
- 876 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
- 877 (ii) basic hospital expense coverage;
- 878 (iii) basic medical/surgical expense coverage;
- 879 (iv) hospital confinement indemnity coverage;
- 880 (v) major medical expense coverage;
- 881 (vi) income replacement or related asset-protection coverage;
- 882 (vii) accident only coverage;
- 883 (viii) coverage for a specified:
- 884 (A) disease; or
- 885 (B) accident;
- 886 (ix) limited benefit health coverage; or
- 887 (x) a life insurance policy that accelerates the death benefit to provide the option of a
- 888 lump sum payment:
- 889 (A) if the following are not conditioned on the receipt of long-term care:
- 890 (I) benefits; or
- 891 (II) eligibility; and
- 892 (B) the coverage is for one or more the following qualifying events:
- 893 (I) terminal illness;

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

895 (III) permanent institutional confinement.

896 (110) "Medical malpractice insurance" means insurance against legal liability incident
897 to the practice and provision of a medical service other than the practice and provision of a
898 dental service.

899 (111) "Member" means a person having membership rights in an insurance
900 corporation.

901 (112) "Minimum capital" or "minimum required capital" means the capital that must be
902 constantly maintained by a stock insurance corporation as required by statute.

903 (113) "Mortgage accident and health insurance" means insurance offered in connection
904 with an extension of credit that provides indemnity for payments coming due on a mortgage
905 while the debtor has a disability.

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

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

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

911 (a) licensed under:

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

913 (ii) Chapter 11, Motor Clubs; or

914 (iii) Chapter 14, Foreign Insurers; and

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

917 (i) legal services under Subsection [31A-11-102\(1\)\(b\)](#);

918 (ii) bail services under Subsection [31A-11-102\(1\)\(c\)](#); or

919 (iii) (A) trip reimbursement;

920 (B) towing services;

921 (C) emergency road services;

922 (D) stolen automobile services;

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

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

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

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

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

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

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

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

934 (a) ships or hulls of ships;

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

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

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

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

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

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

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

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

953 (b) receives:

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

956 (ii) another government health benefit.

957 (125) "Person" includes:

958 (a) an individual;

959 (b) a partnership;

960 (c) a corporation;

961 (d) an incorporated or unincorporated association;

962 (e) a joint stock company;

963 (f) a trust;

964 (g) a limited liability company;

965 (h) a reciprocal;

966 (i) a syndicate; or

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

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

970 (a) an individual; or

971 (b) a family.

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

973 (128) "Plan year" means:

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

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

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

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

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

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

981 or

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

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

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

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

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

987 (129) (a) "Policy" means a document, including an attached endorsement or application
988 that:

989 (i) purports to be an enforceable contract; and
990 (ii) memorializes in writing some or all of the terms of an insurance contract.

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

992 (i) a motor club under Chapter 11, Motor Clubs;
993 (ii) a service contract provided under Chapter 6a, Service Contracts; and
994 (iii) a corporation licensed under:

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

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

997 (c) "Policy" does not include:

998 (i) a certificate under a group insurance contract; or
999 (ii) a document that does not purport to have legal effect.

1000 (130) "Policyholder" means a person who controls a policy, binder, or oral contract by
1001 ownership, premium payment, or otherwise.

1002 (131) "Policy illustration" means a presentation or depiction that includes
1003 nonguaranteed elements of a policy of life insurance over a period of years.

1004 (132) "Policy summary" means a synopsis describing the elements of a life insurance
1005 policy.

1006 (133) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No.
1007 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
1008 related federal regulations and guidance.

1009 (134) "Preexisting condition," with respect to a health benefit plan:

1010 (a) means a condition that was present before the effective date of coverage, whether or
1011 not medical advice, diagnosis, care, or treatment was recommended or received before that day;
1012 and

1013 (b) does not include a condition indicated by genetic information unless an actual
1014 diagnosis of the condition by a physician has been made.

1015 (135) (a) "Premium" means the monetary consideration for an insurance policy.

1016 (b) "Premium" includes, however designated:

1017 (i) an assessment;

- 1018 (ii) a membership fee;
- 1019 (iii) a required contribution; or
- 1020 (iv) monetary consideration.
- 1021 (c) (i) "Premium" does not include consideration paid to a third party administrator for
- 1022 the third party administrator's services.
- 1023 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for
- 1024 insurance on the risks administered by the third party administrator.
- 1025 (136) "Principal officers" for a corporation means the officers designated under
- 1026 Subsection [31A-5-203\(3\)](#).
- 1027 (137) "Proceeding" includes an action or special statutory proceeding.
- 1028 (138) "Professional liability insurance" means insurance against legal liability incident
- 1029 to the practice of a profession and provision of a professional service.
- 1030 (139) (a) Except as provided in Subsection (139)(b), "property insurance" means
- 1031 insurance against loss or damage to real or personal property of every kind and any interest in
- 1032 that property:
- 1033 (i) from all hazards or causes; and
- 1034 (ii) against loss consequential upon the loss or damage including vehicle
- 1035 comprehensive and vehicle physical damage coverages.
- 1036 (b) "Property insurance" does not include:
- 1037 (i) inland marine insurance; and
- 1038 (ii) ocean marine insurance.
- 1039 (140) "Qualified long-term care insurance contract" or "federally tax qualified
- 1040 long-term care insurance contract" means:
- 1041 (a) an individual or group insurance contract that meets the requirements of Section
- 1042 7702B(b), Internal Revenue Code; or
- 1043 (b) the portion of a life insurance contract that provides long-term care insurance:
- 1044 (i) (A) by rider; or
- 1045 (B) as a part of the contract; and
- 1046 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue
- 1047 Code.
- 1048 (141) "Qualified United States financial institution" means an institution that:

- 1049 (a) is:
- 1050 (i) organized under the laws of the United States or any state; or
- 1051 (ii) in the case of a United States office of a foreign banking organization, licensed
- 1052 under the laws of the United States or any state;
- 1053 (b) is regulated, supervised, and examined by a United States federal or state authority
- 1054 having regulatory authority over a bank or trust company; and
- 1055 (c) meets the standards of financial condition and standing that are considered
- 1056 necessary and appropriate to regulate the quality of a financial institution whose letters of credit
- 1057 will be acceptable to the commissioner as determined by:
- 1058 (i) the commissioner by rule; or
- 1059 (ii) the Securities Valuation Office of the National Association of Insurance
- 1060 Commissioners.
- 1061 (142) (a) "Rate" means:
- 1062 (i) the cost of a given unit of insurance; or
- 1063 (ii) for property or casualty insurance, that cost of insurance per exposure unit either
- 1064 expressed as:
- 1065 (A) a single number; or
- 1066 (B) a pure premium rate, adjusted before the application of individual risk variations
- 1067 based on loss or expense considerations to account for the treatment of:
- 1068 (I) expenses;
- 1069 (II) profit; and
- 1070 (III) individual insurer variation in loss experience.
- 1071 (b) "Rate" does not include a minimum premium.
- 1072 (143) (a) Except as provided in Subsection (143)(b), "rate service organization" means
- 1073 a person who assists an insurer in rate making or filing by:
- 1074 (i) collecting, compiling, and furnishing loss or expense statistics;
- 1075 (ii) recommending, making, or filing rates or supplementary rate information; or
- 1076 (iii) advising about rate questions, except as an attorney giving legal advice.
- 1077 (b) "Rate service organization" does not mean:
- 1078 (i) an employee of an insurer;
- 1079 (ii) a single insurer or group of insurers under common control;

- 1080 (iii) a joint underwriting group; or
- 1081 (iv) an individual serving as an actuarial or legal consultant.
- 1082 (144) "Rating manual" means any of the following used to determine initial and
- 1083 renewal policy premiums:
- 1084 (a) a manual of rates;
- 1085 (b) a classification;
- 1086 (c) a rate-related underwriting rule; and
- 1087 (d) a rating formula that describes steps, policies, and procedures for determining
- 1088 initial and renewal policy premiums.
- 1089 (145) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow,
- 1090 or give, directly or indirectly:
- 1091 (i) a refund of premium or portion of premium;
- 1092 (ii) a refund of commission or portion of commission;
- 1093 (iii) a refund of all or a portion of a consultant fee; or
- 1094 (iv) providing services or other benefits not specified in an insurance or annuity
- 1095 contract.
- 1096 (b) "Rebate" does not include:
- 1097 (i) a refund due to termination or changes in coverage;
- 1098 (ii) a refund due to overcharges made in error by the licensee; or
- 1099 (iii) savings or wellness benefits as provided in the contract by the licensee.
- 1100 [~~145~~] (146) "Received by the department" means:
- 1101 (a) the date delivered to and stamped received by the department, if delivered in
- 1102 person;
- 1103 (b) the post mark date, if delivered by mail;
- 1104 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
- 1105 (d) the received date recorded on an item delivered, if delivered by:
- 1106 (i) facsimile;
- 1107 (ii) email; or
- 1108 (iii) another electronic method; or
- 1109 (e) a date specified in:
- 1110 (i) a statute;

1111 (ii) a rule; or

1112 (iii) an order.

1113 [~~(146)~~] (147) "Reciprocal" or "interinsurance exchange" means an unincorporated
1114 association of persons:

1115 (a) operating through an attorney-in-fact common to all of the persons; and

1116 (b) exchanging insurance contracts with one another that provide insurance coverage
1117 on each other.

1118 [~~(147)~~] (148) "Reinsurance" means an insurance transaction where an insurer, for
1119 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1120 reinsurance transactions, this title sometimes refers to:

1121 (a) the insurer transferring the risk as the "ceding insurer"; and

1122 (b) the insurer assuming the risk as the:

1123 (i) "assuming insurer"; or

1124 (ii) "assuming reinsurer."

1125 [~~(148)~~] (149) "Reinsurer" means a person licensed in this state as an insurer with the
1126 authority to assume reinsurance.

1127 [~~(149)~~] (150) "Residential dwelling liability insurance" means insurance against
1128 liability resulting from or incident to the ownership, maintenance, or use of a residential
1129 dwelling that is a detached single family residence or multifamily residence up to four units.

1130 [~~(150)~~] (151) (a) "Retrocession" means reinsurance with another insurer of a liability
1131 assumed under a reinsurance contract.

1132 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a
1133 liability assumed under a reinsurance contract.

1134 [~~(151)~~] (152) "Rider" means an endorsement to:

1135 (a) an insurance policy; or

1136 (b) an insurance certificate.

1137 [~~(152)~~] (153) (a) "Security" means a:

1138 (i) note;

1139 (ii) stock;

1140 (iii) bond;

1141 (iv) debenture;

- 1142 (v) evidence of indebtedness;
- 1143 (vi) certificate of interest or participation in a profit-sharing agreement;
- 1144 (vii) collateral-trust certificate;
- 1145 (viii) preorganization certificate or subscription;
- 1146 (ix) transferable share;
- 1147 (x) investment contract;
- 1148 (xi) voting trust certificate;
- 1149 (xii) certificate of deposit for a security;
- 1150 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
- 1151 payments out of production under such a title or lease;
- 1152 (xiv) commodity contract or commodity option;
- 1153 (xv) certificate of interest or participation in, temporary or interim certificate for,
- 1154 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
- 1155 in Subsections [~~(152)~~] (153)(a)(i) through (xiv); or
- 1156 (xvi) another interest or instrument commonly known as a security.
- 1157 (b) "Security" does not include:
- 1158 (i) any of the following under which an insurance company promises to pay money in a
- 1159 specific lump sum or periodically for life or some other specified period:
- 1160 (A) insurance;
- 1161 (B) an endowment policy; or
- 1162 (C) an annuity contract; or
- 1163 (ii) a burial certificate or burial contract.
- 1164 [~~(153)~~] (154) "Secondary medical condition" means a complication related to an
- 1165 exclusion from coverage in accident and health insurance.
- 1166 [~~(154)~~] (155) (a) "Self-insurance" means an arrangement under which a person
- 1167 provides for spreading its own risks by a systematic plan.
- 1168 (b) Except as provided in this Subsection [~~(154)~~] (155), "self-insurance" does not
- 1169 include an arrangement under which a number of persons spread their risks among themselves.
- 1170 (c) "Self-insurance" includes:
- 1171 (i) an arrangement by which a governmental entity undertakes to indemnify an
- 1172 employee for liability arising out of the employee's employment; and

1173 (ii) an arrangement by which a person with a managed program of self-insurance and
 1174 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
 1175 employees for liability or risk that is related to the relationship or employment.

1176 (d) "Self-insurance" does not include an arrangement with an independent contractor.

1177 ~~[(155)]~~ (156) "Sell" means to exchange a contract of insurance:

1178 (a) by any means;

1179 (b) for money or its equivalent; and

1180 (c) on behalf of an insurance company.

1181 ~~[(156)]~~ (157) "Short-term care insurance" means an insurance policy or rider
 1182 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care
 1183 insurance, but that provides coverage for less than 12 consecutive months for each covered
 1184 person.

1185 ~~[(157)]~~ (158) "Significant break in coverage" means a period of 63 consecutive days
 1186 during each of which an individual does not have creditable coverage.

1187 ~~[(158)]~~ (159) "Small employer[;]" means, in connection with a health benefit plan[;
 1188 ~~means an employer who;~~ and with respect to a calendar year and to a plan year, an employer
 1189 who:

1190 (a) employed ~~[an average of]~~ at least ~~[two employees]~~ one employee but not more than
 1191 an average of 50 eligible employees on ~~[each]~~ business ~~[day]~~ days during the preceding
 1192 calendar year; and

1193 (b) employs at least ~~[two employees]~~ one employee on the first day of the plan year.

1194 ~~[(159)]~~ (160) "Special enrollment period," in connection with a health benefit plan, has
 1195 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance
 1196 Portability and Accountability Act.

1197 ~~[(160)]~~ (161) (a) "Subsidiary" of a person means an affiliate controlled by that person
 1198 either directly or indirectly through one or more affiliates or intermediaries.

1199 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
 1200 shares are owned by that person either alone or with its affiliates, except for the minimum
 1201 number of shares the law of the subsidiary's domicile requires to be owned by directors or
 1202 others.

1203 ~~[(161)]~~ (162) Subject to Subsection (86)(b), "surety insurance" includes:

1204 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or
1205 perform the principal's obligations to a creditor or other obligee;

1206 (b) bail bond insurance; and

1207 (c) fidelity insurance.

1208 [~~(162)~~] (163) (a) "Surplus" means the excess of assets over the sum of paid-in capital
1209 and liabilities.

1210 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is
1211 designated by the insurer or organization as permanent.

1212 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-205 require
1213 that insurers or organizations doing business in this state maintain specified minimum levels of
1214 permanent surplus.

1215 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the
1216 same as the minimum required capital requirement that applies to stock insurers.

1217 (c) "Excess surplus" means:

1218 (i) for a life insurer, accident and health insurer, health organization, or property and
1219 casualty insurer as defined in Section 31A-17-601, the lesser of:

1220 (A) that amount of an insurer's or health organization's total adjusted capital that
1221 exceeds the product of:

1222 (I) 2.5; and

1223 (II) the sum of the insurer's or health organization's minimum capital or permanent
1224 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

1225 (B) that amount of an insurer's or health organization's total adjusted capital that
1226 exceeds the product of:

1227 (I) 3.0; and

1228 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

1229 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer
1230 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

1231 (A) 1.5; and

1232 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

1233 [~~(163)~~] (164) "Third party administrator" or "administrator" means a person who
1234 collects charges or premiums from, or who, for consideration, adjusts or settles claims of

1235 residents of the state in connection with insurance coverage, annuities, or service insurance
1236 coverage, except:

- 1237 (a) a union on behalf of its members;
- 1238 (b) a person administering a:
 - 1239 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1240 1974;
 - 1241 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
 - 1242 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
- 1243 (c) an employer on behalf of the employer's employees or the employees of one or
1244 more of the subsidiary or affiliated corporations of the employer;
- 1245 (d) an insurer licensed under the following, but only for a line of insurance for which
1246 the insurer holds a license in this state:
 - 1247 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
 - 1248 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;
 - 1249 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
 - 1250 (iv) Chapter 9, Insurance Fraternal; or
 - 1251 (v) Chapter 14, Foreign Insurers;
- 1252 (e) a person:
 - 1253 (i) licensed or exempt from licensing under:
 - 1254 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1255 Reinsurance Intermediaries; or
 - 1256 (B) Chapter 26, Insurance Adjusters; and
 - 1257 (ii) whose activities are limited to those authorized under the license the person holds
1258 or for which the person is exempt; or
- 1259 (f) an institution, bank, or financial institution:
 - 1260 (i) that is:
 - 1261 (A) an institution whose deposits and accounts are to any extent insured by a federal
1262 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
1263 Credit Union Administration; or
 - 1264 (B) a bank or other financial institution that is subject to supervision or examination by
1265 a federal or state banking authority; and

1266 (ii) that does not adjust claims without a third party administrator license.

1267 [~~(164)~~] (165) "Title insurance" means the insuring, guaranteeing, or indemnifying of an
1268 owner of real or personal property or the holder of liens or encumbrances on that property, or
1269 others interested in the property against loss or damage suffered by reason of liens or
1270 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
1271 or unenforceability of any liens or encumbrances on the property.

1272 [~~(165)~~] (166) "Total adjusted capital" means the sum of an insurer's or health
1273 organization's statutory capital and surplus as determined in accordance with:

1274 (a) the statutory accounting applicable to the annual financial statements required to be
1275 filed under Section 31A-4-113; and

1276 (b) another item provided by the RBC instructions, as RBC instructions is defined in
1277 Section 31A-17-601.

1278 [~~(166)~~] (167) (a) "Trustee" means "director" when referring to the board of directors of
1279 a corporation.

1280 (b) "Trustee," when used in reference to an employee welfare fund, means an
1281 individual, firm, association, organization, joint stock company, or corporation, whether acting
1282 individually or jointly and whether designated by that name or any other, that is charged with
1283 or has the overall management of an employee welfare fund.

1284 [~~(167)~~] (168) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted
1285 insurer" means an insurer:

1286 (i) not holding a valid certificate of authority to do an insurance business in this state;
1287 or

1288 (ii) transacting business not authorized by a valid certificate.

1289 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1290 (i) holding a valid certificate of authority to do an insurance business in this state; and

1291 (ii) transacting business as authorized by a valid certificate.

1292 [~~(168)~~] (169) "Underwrite" means the authority to accept or reject risk on behalf of the
1293 insurer.

1294 [~~(169)~~] (170) "Vehicle liability insurance" means insurance against liability resulting
1295 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a
1296 vehicle comprehensive or vehicle physical damage coverage under Subsection (139).

1297 [(+170)] (171) "Voting security" means a security with voting rights, and includes a
1298 security convertible into a security with a voting right associated with the security.

1299 [(+171)] (172) "Waiting period" for a health benefit plan means the period that must
1300 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of
1301 the health benefit plan, can become effective.

1302 [(+172)] (173) "Workers' compensation insurance" means:

1303 (a) insurance for indemnification of an employer against liability for compensation
1304 based on:

1305 (i) a compensable accidental injury; and

1306 (ii) occupational disease disability;

1307 (b) employer's liability insurance incidental to workers' compensation insurance and
1308 written in connection with workers' compensation insurance; and

1309 (c) insurance assuring to a person entitled to workers' compensation benefits the
1310 compensation provided by law.

1311 Section 2. Section **31A-2-104** is amended to read:

1312 **31A-2-104. Other employees -- Insurance fraud investigators.**

1313 (1) The department shall employ a chief examiner and such other professional,
1314 technical, and clerical employees as necessary to carry out the duties of the department.

1315 (2) An insurance fraud investigator employed pursuant to Subsection (1) may as
1316 approved by the commissioner:

1317 (a) be designated a [~~special function~~] law enforcement officer, as defined in Section
1318 [~~53-13-105, by the commissioner, but is not~~] 53-13-103; and

1319 (b) be eligible for retirement benefits under the Public Safety Employee's Retirement
1320 System.

1321 Section 3. Section **31A-3-304 (Superseded 07/01/15)** is amended to read:

1322 **31A-3-304 (Superseded 07/01/15). Annual fees -- Other taxes or fees prohibited --**
1323 **Captive Insurance Restricted Account.**

1324 (1) (a) A captive insurance company shall pay an annual fee imposed under this section
1325 to obtain or renew a certificate of authority.

1326 (b) The commissioner shall:

1327 (i) determine the annual fee pursuant to Section 31A-3-103; and

1328 (ii) consider whether the annual fee is competitive with fees imposed by other states on
1329 captive insurance companies.

1330 (2) A captive insurance company that fails to pay the fee required by this section is
1331 subject to the relevant sanctions of this title.

1332 (3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter
1333 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under
1334 the laws of this state that may be levied or assessed on a captive insurance company:

1335 (i) a fee under this section;

1336 (ii) a fee under Chapter 37, Captive Insurance Companies Act; and

1337 (iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company
1338 Act.

1339 (b) The state or a county, city, or town within the state may not levy or collect an
1340 occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii)
1341 against a captive insurance company.

1342 (c) The state may not levy, assess, or collect a withdrawal fee under Section [31A-4-115](#)
1343 against a captive insurance company.

1344 (d) A captive insurance company is subject to real and personal property taxes.

1345 (4) A captive insurance company shall pay the fee imposed by this section to the
1346 commissioner by June ~~[20]~~ 1 of each year.

1347 (5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be
1348 deposited into the Captive Insurance Restricted Account.

1349 (b) There is created in the General Fund a restricted account known as the "Captive
1350 Insurance Restricted Account."

1351 (c) The Captive Insurance Restricted Account shall consist of the fees described in
1352 Subsection (3)(a).

1353 (d) The commissioner shall administer the Captive Insurance Restricted Account.
1354 Subject to appropriations by the Legislature, the commissioner shall use the money deposited
1355 into the Captive Insurance Restricted Account to:

1356 (i) administer and enforce:

1357 (A) Chapter 37, Captive Insurance Companies Act; and

1358 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and

1359 (ii) promote the captive insurance industry in Utah.

1360 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,
1361 except that at the end of each fiscal year, money received by the commissioner in excess of
1362 \$950,000 shall be treated as free revenue in the General Fund.

1363 Section 4. Section 31A-3-304 (Effective 07/01/15) is amended to read:

1364 **31A-3-304 (Effective 07/01/15). Annual fees -- Other taxes or fees prohibited --**
1365 **Captive Insurance Restricted Account.**

1366 (1) (a) A captive insurance company shall pay an annual fee imposed under this section
1367 to obtain or renew a certificate of authority.

1368 (b) The commissioner shall:

1369 (i) determine the annual fee pursuant to Section 31A-3-103; and

1370 (ii) consider whether the annual fee is competitive with fees imposed by other states on
1371 captive insurance companies.

1372 (2) A captive insurance company that fails to pay the fee required by this section is
1373 subject to the relevant sanctions of this title.

1374 (3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter
1375 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under
1376 the laws of this state that may be levied or assessed on a captive insurance company:

1377 (i) a fee under this section;

1378 (ii) a fee under Chapter 37, Captive Insurance Companies Act; and

1379 (iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company
1380 Act.

1381 (b) The state or a county, city, or town within the state may not levy or collect an
1382 occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii)
1383 against a captive insurance company.

1384 (c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115
1385 against a captive insurance company.

1386 (d) A captive insurance company is subject to real and personal property taxes.

1387 (4) A captive insurance company shall pay the fee imposed by this section to the
1388 commissioner by June [20] 1 of each year.

1389 (5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be

1390 deposited into the Captive Insurance Restricted Account.

1391 (b) There is created in the General Fund a restricted account known as the "Captive
1392 Insurance Restricted Account."

1393 (c) The Captive Insurance Restricted Account shall consist of the fees described in
1394 Subsection (3)(a).

1395 (d) The commissioner shall administer the Captive Insurance Restricted Account.
1396 Subject to appropriations by the Legislature, the commissioner shall use the money deposited
1397 into the Captive Insurance Restricted Account to:

1398 (i) administer and enforce:

1399 (A) Chapter 37, Captive Insurance Companies Act; and

1400 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and

1401 (ii) promote the captive insurance industry in Utah.

1402 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,
1403 except that at the end of each fiscal year, money received by the commissioner in excess of
1404 \$1,250,000 shall be treated as free revenue in the General Fund.

1405 Section 5. Section **31A-4-102** is amended to read:

1406 **31A-4-102. Qualified insurers.**

1407 (1) A person may not conduct an insurance business in Utah in person, through an
1408 agent, through a broker, through the mail, or through another method of communication,
1409 except:

1410 (a) an insurer:

1411 (i) authorized to do business in Utah under [~~Chapter 5, 7, 8, 9, 10, 11, 13, or 14, and~~];

1412 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

1413 (B) Chapter 7, Nonprofit Health Service Insurance Corporations;

1414 (C) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

1415 (D) Chapter 9, Insurance Fraternal;

1416 (E) Chapter 10, Annuities;

1417 (F) Chapter 11, Motor Clubs;

1418 (G) Chapter 13, Employee Welfare Funds and Plans;

1419 (H) Chapter 14, Foreign Insurers;

1420 (I) Chapter 37, Captive Insurance Companies Act; or

- 1421 (J) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and
 1422 (ii) within the limits of its certificate of authority;
 1423 (b) a joint underwriting group under Section 31A-2-214 or 31A-20-102;
 1424 (c) an insurer doing business under Section 31A-15-103;
 1425 (d) a person who submits to the commissioner a certificate from the United States
 1426 Department of Labor, or such other evidence as satisfies the commissioner, that the laws of
 1427 Utah are preempted with respect to specified activities of that person by Section 514 of the
 1428 Employee Retirement Income Security Act of 1974 or other federal law; or
 1429 (e) a person exempt from this title under Section 31A-1-103 or another applicable
 1430 statute.
- 1431 (2) As used in this section, "insurer" includes a bail bond surety company, as defined in
 1432 Section 31A-35-102.
- 1433 Section 6. Section 31A-4-115 is amended to read:
 1434 **31A-4-115. Plan of orderly withdrawal.**
- 1435 (1) (a) When an insurer intends to withdraw from writing a line of insurance in this
 1436 state or to reduce its total annual premium volume by 75% or more, the insurer shall file with
 1437 the commissioner a plan of orderly withdrawal.
- 1438 (b) For purposes of this section, a discontinuance of a health benefit plan pursuant to
 1439 one of the following provisions is a withdrawal from a line of insurance:
- 1440 (i) Subsection 31A-30-107(3)(e); or
 1441 (ii) Subsection 31A-30-107.1(3)(e).
- 1442 (2) An insurer's plan of orderly withdrawal shall:
- 1443 (a) indicate the date the insurer intends to begin and complete its withdrawal plan; and
 1444 (b) include provisions for:
- 1445 (i) meeting the insurer's contractual obligations;
 1446 (ii) providing services to its Utah policyholders and claimants;
 1447 (iii) meeting ~~any~~ applicable statutory obligations; and
 1448 (iv) ~~[(A)]~~ the payment of a withdrawal fee of \$50,000 to the ~~[Utah Comprehensive~~
 1449 ~~Health Insurance Pool if: (I) the insurer is an accident and health insurer; and (II) the insurer's~~
 1450 ~~line of business is not assumed or placed with another insurer approved by the commissioner;~~
 1451 ~~or (B) the payment of a withdrawal fee of \$50,000 to the department if: (I) the insurer is not~~

1452 ~~an accident and health insurer; and (H)]~~ department if the insurer's line of business is not
1453 assumed or placed with another insurer approved by the commissioner.

1454 (3) The commissioner shall approve a plan of orderly withdrawal if the plan of orderly
1455 withdrawal adequately demonstrates that the insurer will:

- 1456 (a) protect the interests of the people of the state;
1457 (b) meet the insurer's contractual obligations;
1458 (c) provide service to the insurer's Utah policyholders and claimants; and
1459 (d) meet ~~[any]~~ applicable statutory obligations.

1460 (4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for
1461 orderly withdrawal.

1462 (5) The commissioner may require an insurer to increase the deposit maintained in
1463 accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in
1464 the name of the commissioner upon finding, after an adjudicative proceeding that:

1465 (a) there is reasonable cause to conclude that the interests of the people of the state are
1466 best served by such action; and

1467 (b) the insurer:

- 1468 (i) has filed a plan of orderly withdrawal; or
1469 (ii) intends to:

1470 (A) withdraw from writing a line of insurance in this state; or

1471 (B) reduce the insurer's total annual premium volume by 75% or more.

1472 (6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:

1473 (a) withdraws from writing insurance in this state without receiving the commissioner's
1474 approval of a plan of orderly withdrawal; or

1475 (b) reduces its total annual premium volume by 75% or more in any year without
1476 ~~[having submitted a plan or receiving the commissioner's approval]~~ receiving the
1477 commissioner's approval of a plan of orderly withdrawal.

1478 (7) An insurer that withdraws from writing all lines of insurance in this state may not
1479 resume writing insurance in this state for five years unless~~[-(a)]~~ the commissioner finds that
1480 the prohibition should be waived because the waiver is:

1481 ~~[(i)]~~ (a) in the public interest to promote competition; or

1482 ~~[(ii)]~~ (b) to resolve inequity in the marketplace~~[-and]~~.

1483 ~~[(b) the insurer complies with Subsection 31A-30-108(5), if applicable:]~~

1484 (8) The commissioner shall adopt rules necessary to implement this section.

1485 Section 7. Section 31A-8-402.3 is amended to read:

1486 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**
1487 **plans.**

1488 (1) Except as otherwise provided in this section, a group health benefit plan for a plan
1489 sponsor is renewable and continues in force:

1490 (a) with respect to all eligible employees and dependents; and

1491 (b) at the option of the plan sponsor.

1492 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

1493 (a) for a network plan, if~~[-(i)]~~ there is no longer any enrollee under the group health
1494 plan who lives, resides, or works in:

1495 ~~[(A)]~~ (i) the service area of the insurer; or

1496 ~~[(B)]~~ (ii) the area for which the insurer is authorized to do business; ~~[and]~~ or

1497 ~~[(ii) in the case of the small employer market, the insurer applies the same criteria the~~
1498 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or]~~

1499 (b) for coverage made available in the small or large employer market only through an
1500 association, if:

1501 (i) the employer's membership in the association ceases; and

1502 (ii) the coverage is terminated uniformly without regard to any health status-related
1503 factor relating to any covered individual.

1504 (3) A health benefit plan for a plan sponsor may be discontinued if:

1505 (a) a condition described in Subsection (2) exists;

1506 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
1507 terms of the contract;

1508 (c) the plan sponsor:

1509 (i) performs an act or practice that constitutes fraud; or

1510 (ii) makes an intentional misrepresentation of material fact under the terms of the
1511 coverage;

1512 (d) the insurer:

1513 (i) elects to discontinue offering a particular health benefit product delivered or issued

1514 for delivery in this state; and
1515 (ii) (A) provides notice of the discontinuation in writing:
1516 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1517 (II) at least 90 days before the date the coverage will be discontinued;
1518 (B) provides notice of the discontinuation in writing:
1519 (I) to the commissioner; and
1520 (II) at least three working days prior to the date the notice is sent to the affected plan
1521 sponsors, employees, and dependents of the plan sponsors or employees;
1522 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
1523 (I) all other health benefit products currently being offered by the insurer in the market;
1524 or
1525 (II) in the case of a large employer, any other health benefit product currently being
1526 offered in that market; and
1527 (D) in exercising the option to discontinue that product and in offering the option of
1528 coverage in this section, acts uniformly without regard to:
1529 (I) the claims experience of a plan sponsor;
1530 (II) any health status-related factor relating to any covered participant or beneficiary; or
1531 (III) any health status-related factor relating to any new participant or beneficiary who
1532 may become eligible for the coverage; or
1533 (e) the insurer:
1534 (i) elects to discontinue all of the insurer's health benefit plans in:
1535 (A) the small employer market;
1536 (B) the large employer market; or
1537 (C) both the small employer and large employer markets; and
1538 (ii) (A) provides notice of the discontinuation in writing:
1539 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1540 (II) at least 180 days before the date the coverage will be discontinued;
1541 (B) provides notice of the discontinuation in writing:
1542 (I) to the commissioner in each state in which an affected insured individual is known
1543 to reside; and
1544 (II) at least 30 working days prior to the date the notice is sent to the affected plan

- 1545 sponsors, employees, and the dependents of the plan sponsors or employees;
- 1546 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
1547 market; and
- 1548 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
- 1549 (4) A large employer health benefit plan may be discontinued or nonrenewed:
- 1550 (a) if a condition described in Subsection (2) exists; or
- 1551 (b) for noncompliance with the insurer's:
- 1552 (i) minimum participation requirements; or
- 1553 (ii) employer contribution requirements.
- 1554 (5) A small employer health benefit plan may be discontinued or nonrenewed:
- 1555 (a) if a condition described in Subsection (2) exists; or
- 1556 (b) for noncompliance with the insurer's employer contribution requirements.
- 1557 (6) A small employer health benefit plan may be nonrenewed:
- 1558 (a) if a condition described in Subsection (2) exists; or
- 1559 (b) for noncompliance with the insurer's minimum participation requirements.
- 1560 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
1561 discontinued if after issuance of coverage the eligible employee:
- 1562 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
- 1563 or
- 1564 (ii) makes an intentional misrepresentation of material fact in connection with the
1565 coverage.
- 1566 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
- 1567 (i) 12 months after the date of discontinuance; and
- 1568 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
1569 to reenroll.
- 1570 (c) At the time the eligible employee's coverage is discontinued under Subsection
1571 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
1572 discontinued.
- 1573 (d) An eligible employee may not be discontinued under this Subsection (7) because of
1574 a fraud or misrepresentation that relates to health status.
- 1575 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to

1576 the employer:

1577 (a) with respect to coverage provided to an employer member of the association; and

1578 (b) if the health benefit plan is made available by an insurer in the employer market

1579 only through:

1580 (i) an association;

1581 (ii) a trust; or

1582 (iii) a discretionary group.

1583 (9) An insurer may modify a health benefit plan for a plan sponsor only:

1584 (a) at the time of coverage renewal; and

1585 (b) if the modification is effective uniformly among all plans with that product.

1586 Section 8. Section **31A-16-103** is amended to read:

1587 **31A-16-103. Acquisition of control of or merger with domestic insurer.**

1588 (1) (a) A person may not take the actions described in Subsections (1)(b) or (c) unless,

1589 at the time any offer, request, or invitation is made or any such agreement is entered into, or

1590 prior to the acquisition of securities if no offer or agreement is involved:

1591 (i) the person files with the commissioner a statement containing the information

1592 required by this section;

1593 (ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the

1594 insurer; and

1595 (iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.

1596 (b) Unless the person complies with Subsection (1)(a), a person other than the issuer

1597 may not make a tender offer for, a request or invitation for tenders of, or enter into any

1598 agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise,

1599 any voting security of a domestic insurer if after the acquisition, the person would directly,

1600 indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.

1601 (c) Unless the person complies with Subsection (1)(a), a person may not enter into an

1602 agreement to merge with or otherwise to acquire control of:

1603 (i) a domestic insurer; or

1604 (ii) any person controlling a domestic insurer.

1605 (d) (i) For purposes of this section, a domestic insurer includes any person controlling a

1606 domestic insurer unless the person as determined by the commissioner is either directly or

1607 through its affiliates primarily engaged in business other than the business of insurance.

1608 (ii) The controlling person described in Subsection (1)(d)(i) shall file with the
1609 commissioner a preacquisition notification containing the information required in Subsection
1610 (2) 30 calendar days before the proposed effective date of the acquisition.

1611 (iii) For the purposes of this section, "person" does not include any securities broker
1612 that in the usual and customary brokers function holds less than 20% of:

1613 (A) the voting securities of an insurance company; or

1614 (B) any person that controls an insurance company.

1615 (iv) This section applies to all domestic insurers and other entities licensed under
1616 Chapters 5, 7, 8, 9, and 11.

1617 (e) (i) An agreement for acquisition of control or merger as contemplated by this
1618 Subsection (1) is not valid or enforceable unless the agreement:

1619 (A) is in writing; and

1620 (B) includes a provision that the agreement is subject to the approval of the
1621 commissioner upon the filing of any applicable statement required under this chapter.

1622 (ii) A written agreement for acquisition or control that includes the provision described
1623 in Subsection (1)(e)(i) satisfies the requirements of this Subsection (1).

1624 (2) The statement to be filed with the commissioner under Subsection (1) shall be
1625 made under oath or affirmation and shall contain the following information:

1626 (a) the name and address of the "acquiring party," which means each person by whom
1627 or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to
1628 be effected; and

1629 (i) if the person is an individual:

1630 (A) the person's principal occupation;

1631 (B) a listing of all offices and positions held by the person during the past five years;

1632 and

1633 (C) any conviction of crimes other than minor traffic violations during the past 10
1634 years; and

1635 (ii) if the person is not an individual:

1636 (A) a report of the nature of its business operations during:

1637 (I) the past five years; or

- 1638 (II) for any lesser period as the person and any of its predecessors has been in
1639 existence;
- 1640 (B) an informative description of the business intended to be done by the person and
1641 the person's subsidiaries;
- 1642 (C) a list of all individuals who are or who have been selected to become directors or
1643 executive officers of the person, or individuals who perform, or who will perform functions
1644 appropriate to such positions; and
- 1645 (D) for each individual described in Subsection (2)(a)(ii)(C), the information required
1646 by Subsection (2)(a)(i) for each individual;
- 1647 (b) (i) the source, nature, and amount of the consideration used or to be used in
1648 effecting the merger or acquisition of control;
- 1649 (ii) a description of any transaction in which funds were or are to be obtained for the
1650 purpose of effecting the merger or acquisition of control, including any pledge of:
- 1651 (A) the insurer's stock; or
1652 (B) the stock of any of the insurer's subsidiaries or controlling affiliates; and
1653 (iii) the identity of persons furnishing the consideration;
- 1654 (c) (i) fully audited financial information, or other financial information considered
1655 acceptable by the commissioner, of the earnings and financial condition of each acquiring party
1656 for:
- 1657 (A) the preceding five fiscal years of each acquiring party; or
1658 (B) any lesser period the acquiring party and any of its predecessors shall have been in
1659 existence; and
- 1660 (ii) unaudited information:
- 1661 (A) similar to the information described in Subsection (2)(c)(i); and
1662 (B) prepared within the 90 days prior to the filing of the statement;
- 1663 (d) any plans or proposals which each acquiring party may have to:
- 1664 (i) liquidate the insurer;
1665 (ii) sell its assets;
1666 (iii) merge or consolidate the insurer with any person; or
1667 (iv) make any other material change in the insurer's:
1668 (A) business;

- 1669 (B) corporate structure; or
1670 (C) management;
1671 (e) (i) the number of shares of any security referred to in Subsection (1) that each
1672 acquiring party proposes to acquire;
1673 (ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in
1674 Subsection (1); and
1675 (iii) a statement as to the method by which the fairness of the proposal was arrived at;
1676 (f) the amount of each class of any security referred to in Subsection (1) that:
1677 (i) is beneficially owned; or
1678 (ii) concerning which there is a right to acquire beneficial ownership by each acquiring
1679 party;
1680 (g) a full description of any contract, arrangement, or understanding with respect to any
1681 security referred to in Subsection (1) in which any acquiring party is involved, including:
1682 (i) the transfer of any of the securities;
1683 (ii) joint ventures;
1684 (iii) loan or option arrangements;
1685 (iv) puts or calls;
1686 (v) guarantees of loans;
1687 (vi) guarantees against loss or guarantees of profits;
1688 (vii) division of losses or profits; or
1689 (viii) the giving or withholding of proxies;
1690 (h) a description of the purchase by any acquiring party of any security referred to in
1691 Subsection (1) during the 12 calendar months preceding the filing of the statement including:
1692 (i) the dates of purchase;
1693 (ii) the names of the purchasers; and
1694 (iii) the consideration paid or agreed to be paid for the purchase;
1695 (i) a description of:
1696 (i) any recommendations to purchase by any acquiring party any security referred to in
1697 Subsection (1) made during the 12 calendar months preceding the filing of the statement; or
1698 (ii) any recommendations made by anyone based upon interviews or at the suggestion
1699 of the acquiring party;

1700 (j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange
1701 offers for, and agreements to acquire or exchange any securities referred to in Subsection (1);
1702 and

1703 (ii) if distributed, copies of additional soliciting material relating to the transactions
1704 described in Subsection (2)(j)(i);

1705 (k) (i) the term of any agreement, contract, or understanding made with, or proposed to
1706 be made with, any broker-dealer as to solicitation of securities referred to in Subsection (1) for
1707 tender; and

1708 (ii) the amount of any fees, commissions, or other compensation to be paid to
1709 broker-dealers with regard to any agreement, contract, or understanding described in
1710 Subsection (2)(k)(i); and

1711 (l) any additional information the commissioner requires by rule, which the
1712 commissioner determines to be:

1713 (i) necessary or appropriate for the protection of policyholders of the insurer; or

1714 (ii) in the public interest.

1715 (3) The department may request:

1716 (a) (i) criminal background information maintained pursuant to Title 53, Chapter 10,
1717 Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

1718 (ii) complete Federal Bureau of Investigation criminal background checks through the
1719 national criminal history system.

1720 (b) Information obtained by the department from the review of criminal history records
1721 received under Subsection (3)(a) shall be used by the department for the purpose of:

1722 (i) verifying the information in Subsection (2)(a)(i);

1723 (ii) determining the integrity of persons who would control the operation of an insurer;

1724 and

1725 (iii) preventing persons who violate 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~] from
1726 engaging in the business of insurance in the state.

1727 (c) If the department requests the criminal background information, the department
1728 shall:

1729 (i) pay to the Department of Public Safety the costs incurred by the Department of
1730 Public Safety in providing the department criminal background information under Subsection

- 1731 (3)(a)(i);
- 1732 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
1733 of Investigation in providing the department criminal background information under
1734 Subsection (3)(a)(ii); and
- 1735 (iii) charge the person required to file the statement referred to in Subsection (1) a fee
1736 equal to the aggregate of Subsections (3)(c)(i) and (ii).
- 1737 (4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in
1738 the lender's ordinary course of business, the identity of the lender shall remain confidential, if
1739 the person filing the statement so requests.
- 1740 (b) (i) Under Subsection (2)(e), the commissioner may require a statement of the
1741 adjusted book value assigned by the acquiring party to each security in arriving at the terms of
1742 the offer.
- 1743 (ii) For purposes of this Subsection (4)(b), "adjusted book value" means each security's
1744 proportional interest in the capital and surplus of the insurer with adjustments that reflect:
- 1745 (A) market conditions;
- 1746 (B) business in force; and
- 1747 (C) other intangible assets or liabilities of the insurer.
- 1748 (c) The description required by Subsection (2)(g) shall identify the persons with whom
1749 the contracts, arrangements, or understandings have been entered into.
- 1750 (5) (a) If the person required to file the statement referred to in Subsection (1) is a
1751 partnership, limited partnership, syndicate, or other group, the commissioner may require that
1752 all the information called for by Subsections (2), (3), or (4) shall be given with respect to each:
- 1753 (i) partner of the partnership or limited partnership;
- 1754 (ii) member of the syndicate or group; and
- 1755 (iii) person who controls the partner or member.
- 1756 (b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation,
1757 or if the person required to file the statement referred to in Subsection (1) is a corporation, the
1758 commissioner may require that the information called for by Subsection (2) shall be given with
1759 respect to:
- 1760 (i) the corporation;
- 1761 (ii) each officer and director of the corporation; and

1762 (iii) each person who is directly or indirectly the beneficial owner of more than 10% of
1763 the outstanding voting securities of the corporation.

1764 (6) If any material change occurs in the facts set forth in the statement filed with the
1765 commissioner and sent to the insurer pursuant to Subsection (2), an amendment setting forth
1766 the change, together with copies of all documents and other material relevant to the change,
1767 shall be filed with the commissioner and sent to the insurer within two business days after the
1768 filing person learns of such change.

1769 (7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection
1770 (1) is proposed to be made by means of a registration statement under the Securities Act of
1771 1933, or under circumstances requiring the disclosure of similar information under the
1772 Securities Exchange Act of 1934, or under a state law requiring similar registration or
1773 disclosure, a person required to file the statement referred to in Subsection (1) may use copies
1774 of any registration or disclosure documents in furnishing the information called for by the
1775 statement.

1776 (8) (a) The commissioner shall approve any merger or other acquisition of control
1777 referred to in Subsection (1) unless, after a public hearing on the merger or acquisition, the
1778 commissioner finds that:

1779 (i) after the change of control, the domestic insurer referred to in Subsection (1) would
1780 not be able to satisfy the requirements for the issuance of a license to write the line or lines of
1781 insurance for which it is presently licensed;

1782 (ii) the effect of the merger or other acquisition of control would:

1783 (A) substantially lessen competition in insurance in this state; or

1784 (B) tend to create a monopoly in insurance;

1785 (iii) the financial condition of any acquiring party might:

1786 (A) jeopardize the financial stability of the insurer; or

1787 (B) prejudice the interest of:

1788 (I) its policyholders; or

1789 (II) any remaining securityholders who are unaffiliated with the acquiring party;

1790 (iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in
1791 Subsection (1) are unfair and unreasonable to the securityholders of the insurer;

1792 (v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its

1793 assets, or consolidate or merge it with any person, or to make any other material change in its
1794 business or corporate structure or management, are:

1795 (A) unfair and unreasonable to policyholders of the insurer; and

1796 (B) not in the public interest; or

1797 (vi) the competence, experience, and integrity of those persons who would control the
1798 operation of the insurer are such that it would not be in the interest of the policyholders of the
1799 insurer and the public to permit the merger or other acquisition of control.

1800 (b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not
1801 be considered unfair if the adjusted book values under Subsection (2)(e):

1802 (i) are disclosed to the securityholders; and

1803 (ii) determined by the commissioner to be reasonable.

1804 (9) (a) The public hearing referred to in Subsection (8) shall be held within 30 days
1805 after the statement required by Subsection (1) is filed.

1806 (b) (i) At least 20 days notice of the hearing shall be given by the commissioner to the
1807 person filing the statement.

1808 (ii) Affected parties may waive the notice required by this Subsection (9)(b).

1809 (iii) Not less than seven days notice of the public hearing shall be given by the person
1810 filing the statement to:

1811 (A) the insurer; and

1812 (B) any person designated by the commissioner.

1813 (c) The commissioner shall make a determination within 30 days after the conclusion
1814 of the hearing.

1815 (d) At the hearing, the person filing the statement, the insurer, any person to whom
1816 notice of hearing was sent, and any other person whose interest may be affected by the hearing
1817 may:

1818 (i) present evidence;

1819 (ii) examine and cross-examine witnesses; and

1820 (iii) offer oral and written arguments.

1821 (e) (i) A person or insurer described in Subsection (9)(d) may conduct discovery
1822 proceedings in the same manner as is presently allowed in the district courts of this state.

1823 (ii) All discovery proceedings shall be concluded not later than three days before the

1824 commencement of the public hearing.

1825 (10) (a) The commissioner may retain technical experts to assist in reviewing all, or a
1826 portion of, information filed in connection with a proposed merger or other acquisition of
1827 control referred to in Subsection (1).

1828 (b) In determining whether any of the conditions in Subsection (8) exist, the
1829 commissioner may consider the findings of technical experts employed to review applicable
1830 filings.

1831 (c) (i) A technical expert employed under Subsection (10)(a) shall present to the
1832 commissioner a statement of all expenses incurred by the technical expert in conjunction with
1833 the technical expert's review of a proposed merger or other acquisition of control.

1834 (ii) At the commissioner's direction the acquiring person shall compensate the technical
1835 expert at customary rates for time and expenses:

1836 (A) necessarily incurred; and

1837 (B) approved by the commissioner.

1838 (iii) The acquiring person shall:

1839 (A) certify the consolidated account of all charges and expenses incurred for the review
1840 by technical experts;

1841 (B) retain a copy of the consolidated account described in Subsection (10)(c)(iii)(A);
1842 and

1843 (C) file with the department as a public record a copy of the consolidated account
1844 described in Subsection (10)(c)(iii)(A).

1845 (11) (a) (i) If a domestic insurer proposes to merge into another insurer, any
1846 securityholder electing to exercise a right of dissent may file with the insurer a written request
1847 for payment of the adjusted book value given in the statement required by Subsection (1) and
1848 approved under Subsection (8), in return for the surrender of the security holder's securities.

1849 (ii) The request described in Subsection (11)(a)(i) shall be filed not later than 10 days
1850 after the day of the securityholders' meeting where the corporate action is approved.

1851 (b) The dissenting securityholder is entitled to and the insurer is required to pay to the
1852 dissenting securityholder the specified value within 60 days of receipt of the dissenting security
1853 holder's security.

1854 (c) Persons electing under this Subsection (11) to receive cash for their securities waive

1855 the dissenting shareholder and appraisal rights otherwise applicable under Title 16, Chapter
1856 10a, Part 13, Dissenters' Rights.

1857 (d) (i) This Subsection (11) provides an elective procedure for dissenting
1858 securityholders to resolve their objections to the plan of merger.

1859 (ii) This section does not restrict the rights of dissenting securityholders under Title 16,
1860 Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this
1861 Subsection (11).

1862 (12) (a) All statements, amendments, or other material filed under Subsection (1), and
1863 all notices of public hearings held under Subsection (8), shall be mailed by the insurer to its
1864 securityholders within five business days after the insurer has received the statements,
1865 amendments, other material, or notices.

1866 (b) (i) Mailing expenses shall be paid by the person making the filing.

1867 (ii) As security for the payment of mailing expenses, that person shall file with the
1868 commissioner an acceptable bond or other deposit in an amount determined by the
1869 commissioner.

1870 (13) This section does not apply to any offer, request, invitation, agreement, or
1871 acquisition that the commissioner by order exempts from the requirements of this section as:

1872 (a) not having been made or entered into for the purpose of, and not having the effect
1873 of, changing or influencing the control of a domestic insurer; or

1874 (b) [~~as~~] otherwise not comprehended within the purposes of this section.

1875 (14) The following are violations of this section:

1876 (a) the failure to file any statement, amendment, or other material required to be filed
1877 pursuant to Subsections (1), (2), and (5); or

1878 (b) the effectuation, or any attempt to effectuate, an acquisition of control of or merger
1879 with a domestic insurer unless the commissioner has given the commissioner's approval to the
1880 acquisition or merger.

1881 (15) (a) The courts of this state are vested with jurisdiction over:

1882 (i) a person who:

1883 (A) files a statement with the commissioner under this section; and

1884 (B) is not resident, domiciled, or authorized to do business in this state; and

1885 (ii) overall actions involving persons described in Subsection (15)(a)(i) arising out of a

1886 violation of this section.

1887 (b) A person described in Subsection (15)(a) is considered to have performed acts
1888 equivalent to and constituting an appointment of the commissioner by that person, to be that
1889 person's lawful agent upon whom may be served all lawful process in any action, suit, or
1890 proceeding arising out of a violation of this section.

1891 (c) A copy of a lawful process described in Subsection (15)(b) shall be:

1892 (i) served on the commissioner; and

1893 (ii) transmitted by registered or certified mail by the commissioner to the person at that
1894 person's last-known address.

1895 Section 9. Section **31A-17-607** is amended to read:

1896 **31A-17-607. Hearings.**

1897 (1) (a) Following receipt of a notice described in Subsection (2), the insurer or health
1898 organization shall have the right to a confidential departmental hearing at which the insurer or
1899 health organization may challenge ~~any~~ a determination or action by the commissioner.

1900 (b) The insurer or health organization shall notify the commissioner of its request for a
1901 hearing within five days after the notification by the commissioner under ~~[Subsections~~
1902 ~~31A-17-604(1), (2), and (3)]~~ Subsection (2).

1903 (c) Upon receipt of the insurer's or health organization's request for a hearing, the
1904 commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than
1905 30 days after the date of the insurer's or health organization's request.

1906 (2) An insurer or health organization has the right to a hearing under Subsection (1)
1907 after:

1908 (a) notification to an insurer or health organization by the commissioner of an adjusted
1909 RBC report;

1910 (b) notification to an insurer or health organization by the commissioner that:

1911 (i) the insurer's or health organization's RBC plan or revised RBC plan is
1912 unsatisfactory; and

1913 (ii) the notification constitutes a regulatory action level event with respect to the
1914 insurer or health organization;

1915 (c) notification to any insurer or health organization by the commissioner that the
1916 insurer or health organization has failed to adhere to its RBC plan or revised RBC plan and that

1917 the failure has substantial adverse effect on the ability of the insurer or health organization to
1918 eliminate the company action level event with respect to the insurer or health organization in
1919 accordance with its RBC plan or revised RBC plan; or

1920 (d) notification to an insurer or health organization by the commissioner of a corrective
1921 order with respect to the insurer or health organization.

1922 Section 10. Section **31A-22-305** is amended to read:

1923 **31A-22-305. Uninsured motorist coverage.**

1924 (1) As used in this section, "covered persons" includes:

1925 (a) the named insured;

1926 (b) for a claim arising on or after May 13, 2014, the named insured's dependent minor
1927 children;

1928 ~~[(b)]~~ (c) persons related to the named insured by blood, marriage, adoption, or
1929 guardianship, who are residents of the named insured's household, including those who usually
1930 make their home in the same household but temporarily live elsewhere;

1931 ~~[(c)]~~ (d) any person occupying or using a motor vehicle:

1932 (i) referred to in the policy; or

1933 (ii) owned by a self-insured; and

1934 ~~[(d)]~~ (e) any person who is entitled to recover damages against the owner or operator of
1935 the uninsured or underinsured motor vehicle because of bodily injury to or death of persons
1936 under Subsection (1)(a), (b), ~~[(c)]~~, or (d).

1937 (2) As used in this section, "uninsured motor vehicle" includes:

1938 (a) (i) a motor vehicle, the operation, maintenance, or use of which is not covered
1939 under a liability policy at the time of an injury-causing occurrence; or

1940 (ii) (A) a motor vehicle covered with lower liability limits than required by Section
1941 [31A-22-304](#); and

1942 (B) the motor vehicle described in Subsection (2)(a)(ii)(A) is uninsured to the extent of
1943 the deficiency;

1944 (b) an unidentified motor vehicle that left the scene of an accident proximately caused
1945 by the motor vehicle operator;

1946 (c) a motor vehicle covered by a liability policy, but coverage for an accident is
1947 disputed by the liability insurer for more than 60 days or continues to be disputed for more than

1948 60 days; or

1949 (d) (i) an insured motor vehicle if, before or after the accident, the liability insurer of
1950 the motor vehicle is declared insolvent by a court of competent jurisdiction; and

1951 (ii) the motor vehicle described in Subsection (2)(d)(i) is uninsured only to the extent
1952 that the claim against the insolvent insurer is not paid by a guaranty association or fund.

1953 (3) Uninsured motorist coverage under Subsection 31A-22-302(1)(b) provides
1954 coverage for covered persons who are legally entitled to recover damages from owners or
1955 operators of uninsured motor vehicles because of bodily injury, sickness, disease, or death.

1956 (4) (a) For new policies written on or after January 1, 2001, the limits of uninsured
1957 motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle
1958 liability coverage or the maximum uninsured motorist coverage limits available by the insurer
1959 under the named insured's motor vehicle policy, unless a named insured rejects or purchases
1960 coverage in a lesser amount by signing an acknowledgment form that:

1961 (i) is filed with the department;

1962 (ii) is provided by the insurer;

1963 (iii) waives the higher coverage;

1964 (iv) need only state in this or similar language that uninsured motorist coverage
1965 provides benefits or protection to you and other covered persons for bodily injury resulting
1966 from an accident caused by the fault of another party where the other party has no liability
1967 insurance; and

1968 (v) discloses the additional premiums required to purchase uninsured motorist
1969 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle
1970 liability coverage or the maximum uninsured motorist coverage limits available by the insurer
1971 under the named insured's motor vehicle policy.

1972 (b) Any selection or rejection under this Subsection (4) continues for that issuer of the
1973 liability coverage until the insured requests, in writing, a change of uninsured motorist
1974 coverage from that liability insurer.

1975 (c) (i) Subsections (4)(a) and (b) apply retroactively to any claim arising on or after
1976 January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for
1977 arbitration or filed a complaint in a court of competent jurisdiction.

1978 (ii) The Legislature finds that the retroactive application of Subsections (4)(a) and (b)

1979 clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

1980 (d) For purposes of this Subsection (4), "new policy" means:

1981 (i) any policy that is issued which does not include a renewal or reinstatement of an
1982 existing policy; or

1983 (ii) a change to an existing policy that results in:

1984 (A) a named insured being added to or deleted from the policy; or

1985 (B) a change in the limits of the named insured's motor vehicle liability coverage.

1986 (e) (i) As used in this Subsection (4)(e), "additional motor vehicle" means a change
1987 that increases the total number of vehicles insured by the policy, and does not include
1988 replacement, substitute, or temporary vehicles.

1989 (ii) The adding of an additional motor vehicle to an existing personal lines or
1990 commercial lines policy does not constitute a new policy for purposes of Subsection (4)(d).

1991 (iii) If an additional motor vehicle is added to a personal lines policy where uninsured
1992 motorist coverage has been rejected, or where uninsured motorist limits are lower than the
1993 named insured's motor vehicle liability limits, the insurer shall provide a notice to a named
1994 insured within 30 days that:

1995 (A) in the same manner as described in Subsection (4)(a)(iv), explains the purpose of
1996 uninsured motorist coverage; and

1997 (B) encourages the named insured to contact the insurance company or insurance
1998 producer for quotes as to the additional premiums required to purchase uninsured motorist
1999 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle
2000 liability coverage or the maximum uninsured motorist coverage limits available by the insurer
2001 under the named insured's motor vehicle policy.

2002 (f) A change in policy number resulting from any policy change not identified under
2003 Subsection (4)(d)(ii) does not constitute a new policy.

2004 (g) (i) Subsection (4)(d) applies retroactively to any claim arising on or after January 1,
2005 2001, for which, as of May 1, 2012, an insured has not made a written demand for arbitration
2006 or filed a complaint in a court of competent jurisdiction.

2007 (ii) The Legislature finds that the retroactive application of Subsection (4):

2008 (A) does not enlarge, eliminate, or destroy vested rights; and

2009 (B) clarifies legislative intent.

2010 (h) A self-insured, including a governmental entity, may elect to provide uninsured
2011 motorist coverage in an amount that is less than its maximum self-insured retention under
2012 Subsections (4)(a) and (5)(a) by issuing a declaratory memorandum or policy statement from
2013 the chief financial officer or chief risk officer that declares the:

- 2014 (i) self-insured entity's coverage level; and
- 2015 (ii) process for filing an uninsured motorist claim.

2016 (i) Uninsured motorist coverage may not be sold with limits that are less than the
2017 minimum bodily injury limits for motor vehicle liability policies under Section [31A-22-304](#).

2018 (j) The acknowledgment under Subsection (4)(a) continues for that issuer of the
2019 uninsured motorist coverage until the named insured requests, in writing, different uninsured
2020 motorist coverage from the insurer.

2021 (k) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for
2022 policies existing on that date, the insurer shall disclose in the same medium as the premium
2023 renewal notice, an explanation of:

2024 (A) the purpose of uninsured motorist coverage in the same manner as described in
2025 Subsection (4)(a)(iv); and

2026 (B) a disclosure of the additional premiums required to purchase uninsured motorist
2027 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle
2028 liability coverage or the maximum uninsured motorist coverage limits available by the insurer
2029 under the named insured's motor vehicle policy.

2030 (ii) The disclosure required under Subsection (4)(k)(i) shall be sent to all named
2031 insureds that carry uninsured motorist coverage limits in an amount less than the named
2032 insured's motor vehicle liability policy limits or the maximum uninsured motorist coverage
2033 limits available by the insurer under the named insured's motor vehicle policy.

2034 (l) For purposes of this Subsection (4), a notice or disclosure sent to a named insured in
2035 a household constitutes notice or disclosure to all insureds within the household.

2036 (5) (a) (i) Except as provided in Subsection (5)(b), the named insured may reject
2037 uninsured motorist coverage by an express writing to the insurer that provides liability
2038 coverage under Subsection [31A-22-302\(1\)\(a\)](#).

2039 (ii) This rejection shall be on a form provided by the insurer that includes a reasonable
2040 explanation of the purpose of uninsured motorist coverage.

2041 (iii) This rejection continues for that issuer of the liability coverage until the insured in
2042 writing requests uninsured motorist coverage from that liability insurer.

2043 (b) (i) All persons, including governmental entities, that are engaged in the business of,
2044 or that accept payment for, transporting natural persons by motor vehicle, and all school
2045 districts that provide transportation services for their students, shall provide coverage for all
2046 motor vehicles used for that purpose, by purchase of a policy of insurance or by self-insurance,
2047 uninsured motorist coverage of at least \$25,000 per person and \$500,000 per accident.

2048 (ii) This coverage is secondary to any other insurance covering an injured covered
2049 person.

2050 (c) Uninsured motorist coverage:

2051 (i) is secondary to the benefits provided by Title 34A, Chapter 2, Workers'
2052 Compensation Act;

2053 (ii) may not be subrogated by the workers' compensation insurance carrier;

2054 (iii) may not be reduced by any benefits provided by workers' compensation insurance;

2055 (iv) may be reduced by health insurance subrogation only after the covered person has
2056 been made whole;

2057 (v) may not be collected for bodily injury or death sustained by a person:

2058 (A) while committing a violation of Section [41-1a-1314](#);

2059 (B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated
2060 in violation of Section [41-1a-1314](#); or

2061 (C) while committing a felony; and

2062 (vi) notwithstanding Subsection (5)(c)(v), may be recovered:

2063 (A) for a person under 18 years of age who is injured within the scope of Subsection
2064 (5)(c)(v) but limited to medical and funeral expenses; or

2065 (B) by a law enforcement officer as defined in Section [53-13-103](#), who is injured
2066 within the course and scope of the law enforcement officer's duties.

2067 (d) As used in this Subsection (5), "motor vehicle" has the same meaning as under
2068 Section [41-1a-102](#).

2069 (6) When a covered person alleges that an uninsured motor vehicle under Subsection
2070 (2)(b) proximately caused an accident without touching the covered person or the motor
2071 vehicle occupied by the covered person, the covered person shall show the existence of the

2072 uninsured motor vehicle by clear and convincing evidence consisting of more than the covered
2073 person's testimony.

2074 (7) (a) The limit of liability for uninsured motorist coverage for two or more motor
2075 vehicles may not be added together, combined, or stacked to determine the limit of insurance
2076 coverage available to an injured person for any one accident.

2077 (b) (i) Subsection (7)(a) applies to all persons except a covered person as defined under
2078 Subsection (8)(b)(ii).

2079 (ii) A covered person as defined under Subsection (8)(b)(ii) is entitled to the highest
2080 limits of uninsured motorist coverage afforded for any one motor vehicle that the covered
2081 person is the named insured or an insured family member.

2082 (iii) This coverage shall be in addition to the coverage on the motor vehicle the covered
2083 person is occupying.

2084 (iv) Neither the primary nor the secondary coverage may be set off against the other.

2085 (c) Coverage on a motor vehicle occupied at the time of an accident shall be primary
2086 coverage, and the coverage elected by a person described under Subsections (1)(a) [~~and~~], (b),
2087 and (c) shall be secondary coverage.

2088 (8) (a) Uninsured motorist coverage under this section applies to bodily injury,
2089 sickness, disease, or death of covered persons while occupying or using a motor vehicle only if
2090 the motor vehicle is described in the policy under which a claim is made, or if the motor
2091 vehicle is a newly acquired or replacement motor vehicle covered under the terms of the policy.
2092 Except as provided in Subsection (7) or this Subsection (8), a covered person injured in a
2093 motor vehicle described in a policy that includes uninsured motorist benefits may not elect to
2094 collect uninsured motorist coverage benefits from any other motor vehicle insurance policy
2095 under which the person is a covered person.

2096 (b) Each of the following persons may also recover uninsured motorist benefits under
2097 any one other policy in which they are described as a "covered person" as defined in Subsection
2098 (1):

2099 (i) a covered person injured as a pedestrian by an uninsured motor vehicle; and

2100 (ii) except as provided in Subsection (8)(c), a covered person injured while occupying
2101 or using a motor vehicle that is not owned, leased, or furnished:

2102 (A) to the covered person;

2103 (B) to the covered person's spouse; or
2104 (C) to the covered person's resident parent or resident sibling.
2105 (c) (i) A covered person may recover benefits from no more than two additional
2106 policies, one additional policy from each parent's household if the covered person is:
2107 (A) a dependent minor of parents who reside in separate households; and
2108 (B) injured while occupying or using a motor vehicle that is not owned, leased, or
2109 furnished:
2110 (I) to the covered person;
2111 (II) to the covered person's resident parent; or
2112 (III) to the covered person's resident sibling.
2113 (ii) Each parent's policy under this Subsection (8)(c) is liable only for the percentage of
2114 the damages that the limit of liability of each parent's policy of uninsured motorist coverage
2115 bears to the total of both parents' uninsured coverage applicable to the accident.
2116 (d) A covered person's recovery under any available policies may not exceed the full
2117 amount of damages.
2118 (e) A covered person in Subsection (8)(b) is not barred against making subsequent
2119 elections if recovery is unavailable under previous elections.
2120 (f) (i) As used in this section, "interpolicy stacking" means recovering benefits for a
2121 single incident of loss under more than one insurance policy.
2122 (ii) Except to the extent permitted by Subsection (7) and this Subsection (8),
2123 interpolicy stacking is prohibited for uninsured motorist coverage.
2124 (9) (a) When a claim is brought by a named insured or a person described in
2125 Subsection (1) and is asserted against the covered person's uninsured motorist carrier, the
2126 claimant may elect to resolve the claim:
2127 (i) by submitting the claim to binding arbitration; or
2128 (ii) through litigation.
2129 (b) Unless otherwise provided in the policy under which uninsured benefits are
2130 claimed, the election provided in Subsection (9)(a) is available to the claimant only, except that
2131 if the policy under which insured benefits are claimed provides that either an insured or the
2132 insurer may elect arbitration, the insured or the insurer may elect arbitration and that election to
2133 arbitrate shall stay the litigation of the claim under Subsection (9)(a)(ii).

2134 (c) Once the claimant has elected to commence litigation under Subsection (9)(a)(ii),
2135 the claimant may not elect to resolve the claim through binding arbitration under this section
2136 without the written consent of the uninsured motorist carrier.

2137 (d) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to
2138 binding arbitration under Subsection (9)(a)(i) shall be resolved by a single arbitrator.

2139 (ii) All parties shall agree on the single arbitrator selected under Subsection (9)(d)(i).

2140 (iii) If the parties are unable to agree on a single arbitrator as required under Subsection
2141 (9)(d)(ii), the parties shall select a panel of three arbitrators.

2142 (e) If the parties select a panel of three arbitrators under Subsection (9)(d)(iii):

2143 (i) each side shall select one arbitrator; and

2144 (ii) the arbitrators appointed under Subsection (9)(e)(i) shall select one additional
2145 arbitrator to be included in the panel.

2146 (f) Unless otherwise agreed to in writing:

2147 (i) each party shall pay an equal share of the fees and costs of the arbitrator selected
2148 under Subsection (9)(d)(i); or

2149 (ii) if an arbitration panel is selected under Subsection (9)(d)(iii):

2150 (A) each party shall pay the fees and costs of the arbitrator selected by that party; and

2151 (B) each party shall pay an equal share of the fees and costs of the arbitrator selected
2152 under Subsection (9)(e)(ii).

2153 (g) Except as otherwise provided in this section or unless otherwise agreed to in
2154 writing by the parties, an arbitration proceeding conducted under this section shall be governed
2155 by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

2156 (h) (i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f),
2157 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of
2158 Subsections (10)(a) through (c) are satisfied.

2159 (ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure
2160 shall be determined based on the claimant's specific monetary amount in the written demand
2161 for payment of uninsured motorist coverage benefits as required in Subsection (10)(a)(i)(A).

2162 (iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to
2163 arbitration claims under this part.

2164 (i) All issues of discovery shall be resolved by the arbitrator or the arbitration panel.

2165 (j) A written decision by a single arbitrator or by a majority of the arbitration panel
2166 shall constitute a final decision.

2167 (k) (i) Except as provided in Subsection (10), the amount of an arbitration award may
2168 not exceed the uninsured motorist policy limits of all applicable uninsured motorist policies,
2169 including applicable uninsured motorist umbrella policies.

2170 (ii) If the initial arbitration award exceeds the uninsured motorist policy limits of all
2171 applicable uninsured motorist policies, the arbitration award shall be reduced to an amount
2172 equal to the combined uninsured motorist policy limits of all applicable uninsured motorist
2173 policies.

2174 (l) The arbitrator or arbitration panel may not decide the issues of coverage or
2175 extra-contractual damages, including:

2176 (i) whether the claimant is a covered person;

2177 (ii) whether the policy extends coverage to the loss; or

2178 (iii) any allegations or claims asserting consequential damages or bad faith liability.

2179 (m) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or
2180 class-representative basis.

2181 (n) If the arbitrator or arbitration panel finds that the action was not brought, pursued,
2182 or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees
2183 and costs against the party that failed to bring, pursue, or defend the claim in good faith.

2184 (o) An arbitration award issued under this section shall be the final resolution of all
2185 claims not excluded by Subsection (9)(l) between the parties unless:

2186 (i) the award was procured by corruption, fraud, or other undue means;

2187 (ii) either party, within 20 days after service of the arbitration award:

2188 (A) files a complaint requesting a trial de novo in the district court; and

2189 (B) serves the nonmoving party with a copy of the complaint requesting a trial de novo
2190 under Subsection (9)(o)(ii)(A).

2191 (p) (i) Upon filing a complaint for a trial de novo under Subsection (9)(o), the claim
2192 shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules
2193 of Evidence in the district court.

2194 (ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may
2195 request a jury trial with a complaint requesting a trial de novo under Subsection (9)(o)(ii)(A).

2196 (q) (i) If the claimant, as the moving party in a trial de novo requested under
2197 Subsection (9)(o), does not obtain a verdict that is at least \$5,000 and is at least 20% greater
2198 than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

2199 (ii) If the uninsured motorist carrier, as the moving party in a trial de novo requested
2200 under Subsection (9)(o), does not obtain a verdict that is at least 20% less than the arbitration
2201 award, the uninsured motorist carrier is responsible for all of the nonmoving party's costs.

2202 (iii) Except as provided in Subsection (9)(q)(iv), the costs under this Subsection (9)(q)
2203 shall include:

2204 (A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

2205 (B) the costs of expert witnesses and depositions.

2206 (iv) An award of costs under this Subsection (9)(q) may not exceed \$2,500 unless
2207 Subsection (10)(h)(iii) applies.

2208 (r) For purposes of determining whether a party's verdict is greater or less than the
2209 arbitration award under Subsection (9)(q), a court may not consider any recovery or other relief
2210 granted on a claim for damages if the claim for damages:

2211 (i) was not fully disclosed in writing prior to the arbitration proceeding; or

2212 (ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil
2213 Procedure.

2214 (s) If a district court determines, upon a motion of the nonmoving party, that the
2215 moving party's use of the trial de novo process was filed in bad faith in accordance with
2216 Section [78B-5-825](#), the district court may award reasonable attorney fees to the nonmoving
2217 party.

2218 (t) Nothing in this section is intended to limit any claim under any other portion of an
2219 applicable insurance policy.

2220 (u) If there are multiple uninsured motorist policies, as set forth in Subsection (8), the
2221 claimant may elect to arbitrate in one hearing the claims against all the uninsured motorist
2222 carriers.

2223 (10) (a) Within 30 days after a covered person elects to submit a claim for uninsured
2224 motorist benefits to binding arbitration or files litigation, the covered person shall provide to
2225 the uninsured motorist carrier:

2226 (i) a written demand for payment of uninsured motorist coverage benefits, setting forth:

2227 (A) subject to Subsection (10)(I), the specific monetary amount of the demand,
2228 including a computation of the covered person's claimed past medical expenses, claimed past
2229 lost wages, and the other claimed past economic damages; and

2230 (B) the factual and legal basis and any supporting documentation for the demand;

2231 (ii) a written statement under oath disclosing:

2232 (A) (I) the names and last known addresses of all health care providers who have
2233 rendered health care services to the covered person that are material to the claims for which
2234 uninsured motorist benefits are sought for a period of five years preceding the date of the event
2235 giving rise to the claim for uninsured motorist benefits up to the time the election for
2236 arbitration or litigation has been exercised; and

2237 (II) [~~whether the covered person has seen other~~] the names and last known addresses of
2238 the health care providers who have rendered health care services to the covered person, which
2239 the covered person claims are immaterial to the claims for which uninsured motorist benefits
2240 are sought, for a period of five years preceding the date of the event giving rise to the claim for
2241 uninsured motorist benefits up to the time the election for arbitration or litigation has been
2242 exercised that have not been disclosed under Subsection (10)(a)(ii)(A)(I);

2243 (B) (I) the names and last known addresses of all health insurers or other entities to
2244 whom the covered person has submitted claims for health care services or benefits material to
2245 the claims for which uninsured motorist benefits are sought, for a period of five years
2246 preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the
2247 time the election for arbitration or litigation has been exercised; and

2248 (II) [~~whether the identity of any~~] the names and last known addresses of the health
2249 insurers or other entities to whom the covered person has submitted claims for health care
2250 services or benefits, which the covered person claims are immaterial to the claims for which
2251 uninsured motorist benefits are sought, for a period of five years preceding the date of the event
2252 giving rise to the claim for uninsured motorist benefits up to the time the election for
2253 arbitration or litigation have not been disclosed;

2254 (C) if lost wages, diminished earning capacity, or similar damages are claimed, all
2255 employers of the covered person for a period of five years preceding the date of the event
2256 giving rise to the claim for uninsured motorist benefits up to the time the election for
2257 arbitration or litigation has been exercised;

2258 (D) other documents to reasonably support the claims being asserted; and
2259 (E) all state and federal statutory lienholders including a statement as to whether the
2260 covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health
2261 Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act,
2262 or if the claim is subject to any other state or federal statutory liens; and
2263 (iii) signed authorizations to allow the uninsured motorist carrier to only obtain records
2264 and billings from the individuals or entities disclosed under Subsections (10)(a)(ii)(A)(I),
2265 (B)(I), and (C).
2266 (b) (i) If the uninsured motorist carrier determines that the disclosure of undisclosed
2267 health care providers or health care insurers under Subsection (10)(a)(ii) is reasonably
2268 necessary, the uninsured motorist carrier may:
2269 (A) make a request for the disclosure of the identity of the health care providers or
2270 health care insurers; and
2271 (B) make a request for authorizations to allow the uninsured motorist carrier to only
2272 obtain records and billings from the individuals or entities not disclosed.
2273 (ii) If the covered person does not provide the requested information within 10 days:
2274 (A) the covered person shall disclose, in writing, the legal or factual basis for the
2275 failure to disclose the health care providers or health care insurers; and
2276 (B) either the covered person or the uninsured motorist carrier may request the
2277 arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be
2278 provided if the covered person has elected arbitration.
2279 (iii) The time periods imposed by Subsection (10)(c)(i) are tolled pending resolution of
2280 the dispute concerning the disclosure and production of records of the health care providers or
2281 health care insurers.
2282 (c) (i) An uninsured motorist carrier that receives an election for arbitration or a notice
2283 of filing litigation and the demand for payment of uninsured motorist benefits under Subsection
2284 (10)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and
2285 receipt of the items specified in Subsections (10)(a)(i) through (iii), to:
2286 (A) provide a written response to the written demand for payment provided for in
2287 Subsection (10)(a)(i);
2288 (B) except as provided in Subsection (10)(c)(i)(C), tender the amount, if any, of the

2289 uninsured motorist carrier's determination of the amount owed to the covered person; and

2290 (C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah
2291 Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's
2292 Health Insurance Act, or if the claim is subject to any other state or federal statutory liens,
2293 tender the amount, if any, of the uninsured motorist carrier's determination of the amount owed
2294 to the covered person less:

2295 (I) if the amount of the state or federal statutory lien is established, the amount of the
2296 lien; or

2297 (II) if the amount of the state or federal statutory lien is not established, two times the
2298 amount of the medical expenses subject to the state or federal statutory lien until such time as
2299 the amount of the state or federal statutory lien is established.

2300 (ii) If the amount tendered by the uninsured motorist carrier under Subsection (10)(c)(i)
2301 is the total amount of the uninsured motorist policy limits, the tendered amount shall be
2302 accepted by the covered person.

2303 (d) A covered person who receives a written response from an uninsured motorist
2304 carrier as provided for in Subsection (10)(c)(i), may:

2305 (i) elect to accept the amount tendered in Subsection (10)(c)(i) as payment in full of all
2306 uninsured motorist claims; or

2307 (ii) elect to:

2308 (A) accept the amount tendered in Subsection (10)(c)(i) as partial payment of all
2309 uninsured motorist claims; and

2310 (B) continue to litigate or arbitrate the remaining claim in accordance with the election
2311 made under Subsections (9)(a), (b), and (c).

2312 (e) If a covered person elects to accept the amount tendered under Subsection (10)(c)(i)
2313 as partial payment of all uninsured motorist claims, the final award obtained through
2314 arbitration, litigation, or later settlement shall be reduced by any payment made by the
2315 uninsured motorist carrier under Subsection (10)(c)(i).

2316 (f) In an arbitration proceeding on the remaining uninsured claims:

2317 (i) the parties may not disclose to the arbitrator or arbitration panel the amount paid
2318 under Subsection (10)(c)(i) until after the arbitration award has been rendered; and

2319 (ii) the parties may not disclose the amount of the limits of uninsured motorist benefits

2320 provided by the policy.

2321 (g) If the final award obtained through arbitration or litigation is greater than the
2322 average of the covered person's initial written demand for payment provided for in Subsection
2323 (10)(a)(i) and the uninsured motorist carrier's initial written response provided for in
2324 Subsection (10)(c)(i), the uninsured motorist carrier shall pay:

2325 (i) the final award obtained through arbitration or litigation, except that if the award
2326 exceeds the policy limits of the subject uninsured motorist policy by more than \$15,000, the
2327 amount shall be reduced to an amount equal to the policy limits plus \$15,000; and

2328 (ii) any of the following applicable costs:

2329 (A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

2330 (B) the arbitrator or arbitration panel's fee; and

2331 (C) the reasonable costs of expert witnesses and depositions used in the presentation of
2332 evidence during arbitration or litigation.

2333 (h) (i) The covered person shall provide an affidavit of costs within five days of an
2334 arbitration award.

2335 (ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to
2336 which the uninsured motorist carrier objects.

2337 (B) The objection shall be resolved by the arbitrator or arbitration panel.

2338 (iii) The award of costs by the arbitrator or arbitration panel under Subsection
2339 (10)(g)(ii) may not exceed \$5,000.

2340 (i) (i) A covered person shall disclose all material information, other than rebuttal
2341 evidence, within 30 days after a covered person elects to submit a claim for uninsured motorist
2342 coverage benefits to binding arbitration or files litigation as specified in Subsection (10)(a).

2343 (ii) If the information under Subsection (10)(i)(i) is not disclosed, the covered person
2344 may not recover costs or any amounts in excess of the policy under Subsection (10)(g).

2345 (j) This Subsection (10) does not limit any other cause of action that arose or may arise
2346 against the uninsured motorist carrier from the same dispute.

2347 (k) The provisions of this Subsection (10) only apply to motor vehicle accidents that
2348 occur on or after March 30, 2010.

2349 (l) (i) The written demand requirement in Subsection (10)(a)(i)(A) does not affect the
2350 covered person's requirement to provide a computation of any other economic damages

2351 claimed, and the one or more respondents shall have a reasonable time after the receipt of the
2352 computation of any other economic damages claimed to conduct fact and expert discovery as
2353 to any additional damages claimed. The changes made by this bill to this Subsection (10)(l)
2354 and Subsection (10)(a)(i)(A) apply to a claim submitted to binding arbitration or through
2355 litigation on or after May 13, 2014.

2356 (ii) The changes made by this bill to Subsections (10)(a)(ii)(A)(II) and (B)(II) apply to
2357 any claim submitted to binding arbitration or through litigation on or after May 13, 2014.

2358 Section 11. Section **31A-22-305.3** is amended to read:

2359 **31A-22-305.3. Underinsured motorist coverage.**

2360 (1) As used in this section:

2361 (a) "Covered person" has the same meaning as defined in Section [31A-22-305](#).

2362 (b) (i) "Underinsured motor vehicle" includes a motor vehicle, the operation,
2363 maintenance, or use of which is covered under a liability policy at the time of an injury-causing
2364 occurrence, but which has insufficient liability coverage to compensate fully the injured party
2365 for all special and general damages.

2366 (ii) The term "underinsured motor vehicle" does not include:

2367 (A) a motor vehicle that is covered under the liability coverage of the same policy that
2368 also contains the underinsured motorist coverage;

2369 (B) an uninsured motor vehicle as defined in Subsection [31A-22-305\(2\)](#); or

2370 (C) a motor vehicle owned or leased by:

2371 (I) a named insured;

2372 (II) a named insured's spouse; or

2373 (III) a dependent of a named insured.

2374 (2) (a) Underinsured motorist coverage under Subsection [31A-22-302\(1\)\(c\)](#) provides
2375 coverage for a covered person who is legally entitled to recover damages from an owner or
2376 operator of an underinsured motor vehicle because of bodily injury, sickness, disease, or death.

2377 (b) A covered person occupying or using a motor vehicle owned, leased, or furnished
2378 to the covered person, the covered person's spouse, or covered person's resident relative may
2379 recover underinsured benefits only if the motor vehicle is:

2380 (i) described in the policy under which a claim is made; or

2381 (ii) a newly acquired or replacement motor vehicle covered under the terms of the

2382 policy.

2383 (3) (a) For new policies written on or after January 1, 2001, the limits of underinsured
2384 motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle
2385 liability coverage or the maximum underinsured motorist coverage limits available by the
2386 insurer under the named insured's motor vehicle policy, unless a named insured rejects or
2387 purchases coverage in a lesser amount by signing an acknowledgment form that:

2388 (i) is filed with the department;

2389 (ii) is provided by the insurer;

2390 (iii) waives the higher coverage;

2391 (iv) need only state in this or similar language that underinsured motorist coverage
2392 provides benefits or protection to you and other covered persons for bodily injury resulting
2393 from an accident caused by the fault of another party where the other party has insufficient
2394 liability insurance; and

2395 (v) discloses the additional premiums required to purchase underinsured motorist
2396 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle
2397 liability coverage or the maximum underinsured motorist coverage limits available by the
2398 insurer under the named insured's motor vehicle policy.

2399 (b) Any selection or rejection under Subsection (3)(a) continues for that issuer of the
2400 liability coverage until the insured requests, in writing, a change of underinsured motorist
2401 coverage from that liability insurer.

2402 (c) (i) Subsections (3)(a) and (b) apply retroactively to any claim arising on or after
2403 January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for
2404 arbitration or filed a complaint in a court of competent jurisdiction.

2405 (ii) The Legislature finds that the retroactive application of Subsections (3)(a) and (b)
2406 clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

2407 (d) For purposes of this Subsection (3), "new policy" means:

2408 (i) any policy that is issued which does not include a renewal or reinstatement of an
2409 existing policy; or

2410 (ii) a change to an existing policy that results in:

2411 (A) a named insured being added to or deleted from the policy; or

2412 (B) a change in the limits of the named insured's motor vehicle liability coverage.

2413 (e) (i) As used in this Subsection (3)(e), "additional motor vehicle" means a change
2414 that increases the total number of vehicles insured by the policy, and does not include
2415 replacement, substitute, or temporary vehicles.

2416 (ii) The adding of an additional motor vehicle to an existing personal lines or
2417 commercial lines policy does not constitute a new policy for purposes of Subsection (3)(d).

2418 (iii) If an additional motor vehicle is added to a personal lines policy where
2419 underinsured motorist coverage has been rejected, or where underinsured motorist limits are
2420 lower than the named insured's motor vehicle liability limits, the insurer shall provide a notice
2421 to a named insured within 30 days that:

2422 (A) in the same manner described in Subsection (3)(a)(iv), explains the purpose of
2423 underinsured motorist coverage; and

2424 (B) encourages the named insured to contact the insurance company or insurance
2425 producer for quotes as to the additional premiums required to purchase underinsured motorist
2426 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle
2427 liability coverage or the maximum underinsured motorist coverage limits available by the
2428 insurer under the named insured's motor vehicle policy.

2429 (f) A change in policy number resulting from any policy change not identified under
2430 Subsection (3)(d)(ii) does not constitute a new policy.

2431 (g) (i) Subsection (3)(d) applies retroactively to any claim arising on or after January 1,
2432 2001 for which, as of May 1, 2012, an insured has not made a written demand for arbitration or
2433 filed a complaint in a court of competent jurisdiction.

2434 (ii) The Legislature finds that the retroactive application of Subsection (3)(d):

2435 (A) does not enlarge, eliminate, or destroy vested rights; and

2436 (B) clarifies legislative intent.

2437 (h) A self-insured, including a governmental entity, may elect to provide underinsured
2438 motorist coverage in an amount that is less than its maximum self-insured retention under
2439 Subsections (3)(a) and (l) by issuing a declaratory memorandum or policy statement from the
2440 chief financial officer or chief risk officer that declares the:

2441 (i) self-insured entity's coverage level; and

2442 (ii) process for filing an underinsured motorist claim.

2443 (i) Underinsured motorist coverage may not be sold with limits that are less than:

- 2444 (i) \$10,000 for one person in any one accident; and
2445 (ii) at least \$20,000 for two or more persons in any one accident.
- 2446 (j) An acknowledgment under Subsection (3)(a) continues for that issuer of the
2447 underinsured motorist coverage until the named insured, in writing, requests different
2448 underinsured motorist coverage from the insurer.
- 2449 (k) (i) The named insured's underinsured motorist coverage, as described in Subsection
2450 (2), is secondary to the liability coverage of an owner or operator of an underinsured motor
2451 vehicle, as described in Subsection (1).
- 2452 (ii) Underinsured motorist coverage may not be set off against the liability coverage of
2453 the owner or operator of an underinsured motor vehicle, but shall be added to, combined with,
2454 or stacked upon the liability coverage of the owner or operator of the underinsured motor
2455 vehicle to determine the limit of coverage available to the injured person.
- 2456 (l) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for
2457 policies existing on that date, the insurer shall disclose in the same medium as the premium
2458 renewal notice, an explanation of:
- 2459 (A) the purpose of underinsured motorist coverage in the same manner as described in
2460 Subsection (3)(a)(iv); and
- 2461 (B) a disclosure of the additional premiums required to purchase underinsured motorist
2462 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle
2463 liability coverage or the maximum underinsured motorist coverage limits available by the
2464 insurer under the named insured's motor vehicle policy.
- 2465 (ii) The disclosure required under this Subsection (3)(l) shall be sent to all named
2466 insureds that carry underinsured motorist coverage limits in an amount less than the named
2467 insured's motor vehicle liability policy limits or the maximum underinsured motorist coverage
2468 limits available by the insurer under the named insured's motor vehicle policy.
- 2469 (m) For purposes of this Subsection (3), a notice or disclosure sent to a named insured
2470 in a household constitutes notice or disclosure to all insureds within the household.
- 2471 (4) (a) (i) Except as provided in this Subsection (4), a covered person injured in a
2472 motor vehicle described in a policy that includes underinsured motorist benefits may not elect
2473 to collect underinsured motorist coverage benefits from another motor vehicle insurance policy.
- 2474 (ii) The limit of liability for underinsured motorist coverage for two or more motor

2475 vehicles may not be added together, combined, or stacked to determine the limit of insurance
2476 coverage available to an injured person for any one accident.

2477 (iii) Subsection (4)(a)(ii) applies to all persons except a covered person described
2478 under Subsections (4)(b)(i) and (ii).

2479 (b) (i) Except as provided in Subsection (4)(b)(ii), a covered person injured while
2480 occupying, using, or maintaining a motor vehicle that is not owned, leased, or furnished to the
2481 covered person, the covered person's spouse, or the covered person's resident parent or resident
2482 sibling, may also recover benefits under any one other policy under which the covered person is
2483 also a covered person.

2484 (ii) (A) A covered person may recover benefits from no more than two additional
2485 policies, one additional policy from each parent's household if the covered person is:

2486 (I) a dependent minor of parents who reside in separate households; and

2487 (II) injured while occupying or using a motor vehicle that is not owned, leased, or
2488 furnished to the covered person, the covered person's resident parent, or the covered person's
2489 resident sibling.

2490 (B) Each parent's policy under this Subsection (4)(b)(ii) is liable only for the
2491 percentage of the damages that the limit of liability of each parent's policy of underinsured
2492 motorist coverage bears to the total of both parents' underinsured coverage applicable to the
2493 accident.

2494 (iii) A covered person's recovery under any available policies may not exceed the full
2495 amount of damages.

2496 (iv) Underinsured coverage on a motor vehicle occupied at the time of an accident is
2497 primary coverage, and the coverage elected by a person described under Subsections
2498 [31A-22-305\(1\)\(a\)](#) [~~and~~], (b), and (c) is secondary coverage.

2499 (v) The primary and the secondary coverage may not be set off against the other.

2500 (vi) A covered person as described under Subsection (4)(b)(i) is entitled to the highest
2501 limits of underinsured motorist coverage under only one additional policy per household
2502 applicable to that covered person as a named insured, spouse, or relative.

2503 (vii) A covered injured person is not barred against making subsequent elections if
2504 recovery is unavailable under previous elections.

2505 (viii) (A) As used in this section, "interpolicy stacking" means recovering benefits for a

2506 single incident of loss under more than one insurance policy.

2507 (B) Except to the extent permitted by this Subsection (4), interpolicy stacking is

2508 prohibited for underinsured motorist coverage.

2509 (c) Underinsured motorist coverage:

2510 (i) is secondary to the benefits provided by Title 34A, Chapter 2, Workers'

2511 Compensation Act;

2512 (ii) may not be subrogated by a workers' compensation insurance carrier;

2513 (iii) may not be reduced by benefits provided by workers' compensation insurance;

2514 (iv) may be reduced by health insurance subrogation only after the covered person is

2515 made whole;

2516 (v) may not be collected for bodily injury or death sustained by a person:

2517 (A) while committing a violation of Section 41-1a-1314;

2518 (B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated

2519 in violation of Section 41-1a-1314; or

2520 (C) while committing a felony; and

2521 (vi) notwithstanding Subsection (4)(c)(v), may be recovered:

2522 (A) for a person under 18 years of age who is injured within the scope of Subsection

2523 (4)(c)(v), but is limited to medical and funeral expenses; or

2524 (B) by a law enforcement officer as defined in Section 53-13-103, who is injured

2525 within the course and scope of the law enforcement officer's duties.

2526 (5) The inception of the loss under Subsection 31A-21-313(1) for underinsured

2527 motorist claims occurs upon the date of the last liability policy payment.

2528 (6) (a) Within five business days after notification that all liability insurers have

2529 tendered their liability policy limits, the underinsured carrier shall either:

2530 (i) waive any subrogation claim the underinsured carrier may have against the person

2531 liable for the injuries caused in the accident; or

2532 (ii) pay the insured an amount equal to the policy limits tendered by the liability carrier.

2533 (b) If neither option is exercised under Subsection (6)(a), the subrogation claim is

2534 considered to be waived by the underinsured carrier.

2535 (c) The notification under Subsection (6)(a) shall include:

2536 (i) the name, address, and phone number for all liability insurers;

- 2537 (ii) the liability insurers' liability policy limits; and
2538 (iii) the claim number associated with each liability insurer.
- 2539 (7) Except as otherwise provided in this section, a covered person may seek, subject to
2540 the terms and conditions of the policy, additional coverage under any policy:
- 2541 (a) that provides coverage for damages resulting from motor vehicle accidents; and
2542 (b) that is not required to conform to Section [31A-22-302](#).
- 2543 (8) (a) When a claim is brought by a named insured or a person described in
2544 Subsection [31A-22-305](#)(1) and is asserted against the covered person's underinsured motorist
2545 carrier, the claimant may elect to resolve the claim:
- 2546 (i) by submitting the claim to binding arbitration; or
2547 (ii) through litigation.
- 2548 (b) Unless otherwise provided in the policy under which underinsured benefits are
2549 claimed, the election provided in Subsection (8)(a) is available to the claimant only, except that
2550 if the policy under which insured benefits are claimed provides that either an insured or the
2551 insurer may elect arbitration, the insured or the insurer may elect arbitration and that election to
2552 arbitrate shall stay the litigation of the claim under Subsection (8)(a)(ii).
- 2553 (c) Once a claimant elects to commence litigation under Subsection (8)(a)(ii), the
2554 claimant may not elect to resolve the claim through binding arbitration under this section
2555 without the written consent of the underinsured motorist coverage carrier.
- 2556 (d) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to
2557 binding arbitration under Subsection (8)(a)(i) shall be resolved by a single arbitrator.
- 2558 (ii) All parties shall agree on the single arbitrator selected under Subsection (8)(d)(i).
2559 (iii) If the parties are unable to agree on a single arbitrator as required under Subsection
2560 (8)(d)(ii), the parties shall select a panel of three arbitrators.
- 2561 (e) If the parties select a panel of three arbitrators under Subsection (8)(d)(iii):
2562 (i) each side shall select one arbitrator; and
2563 (ii) the arbitrators appointed under Subsection (8)(e)(i) shall select one additional
2564 arbitrator to be included in the panel.
- 2565 (f) Unless otherwise agreed to in writing:
2566 (i) each party shall pay an equal share of the fees and costs of the arbitrator selected
2567 under Subsection (8)(d)(i); or

2568 (ii) if an arbitration panel is selected under Subsection (8)(d)(iii):
2569 (A) each party shall pay the fees and costs of the arbitrator selected by that party; and
2570 (B) each party shall pay an equal share of the fees and costs of the arbitrator selected
2571 under Subsection (8)(e)(ii).

2572 (g) Except as otherwise provided in this section or unless otherwise agreed to in
2573 writing by the parties, an arbitration proceeding conducted under this section is governed by
2574 Title 78B, Chapter 11, Utah Uniform Arbitration Act.

2575 (h) (i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f),
2576 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of
2577 Subsections (9)(a) through (c) are satisfied.

2578 (ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure
2579 shall be determined based on the claimant's specific monetary amount in the written demand
2580 for payment of uninsured motorist coverage benefits as required in Subsection (9)(a)(i)(A).

2581 (iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to
2582 arbitration claims under this part.

2583 (i) An issue of discovery shall be resolved by the arbitrator or the arbitration panel.

2584 (j) A written decision by a single arbitrator or by a majority of the arbitration panel
2585 constitutes a final decision.

2586 (k) (i) Except as provided in Subsection (9), the amount of an arbitration award may
2587 not exceed the underinsured motorist policy limits of all applicable underinsured motorist
2588 policies, including applicable underinsured motorist umbrella policies.

2589 (ii) If the initial arbitration award exceeds the underinsured motorist policy limits of all
2590 applicable underinsured motorist policies, the arbitration award shall be reduced to an amount
2591 equal to the combined underinsured motorist policy limits of all applicable underinsured
2592 motorist policies.

2593 (l) The arbitrator or arbitration panel may not decide an issue of coverage or
2594 extra-contractual damages, including:

2595 (i) whether the claimant is a covered person;

2596 (ii) whether the policy extends coverage to the loss; or

2597 (iii) an allegation or claim asserting consequential damages or bad faith liability.

2598 (m) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or

2599 class-representative basis.

2600 (n) If the arbitrator or arbitration panel finds that the arbitration is not brought, pursued,
2601 or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees
2602 and costs against the party that failed to bring, pursue, or defend the arbitration in good faith.

2603 (o) An arbitration award issued under this section shall be the final resolution of all
2604 claims not excluded by Subsection (8)(l) between the parties unless:

2605 (i) the award is procured by corruption, fraud, or other undue means;

2606 (ii) either party, within 20 days after service of the arbitration award:

2607 (A) files a complaint requesting a trial de novo in the district court; and

2608 (B) serves the nonmoving party with a copy of the complaint requesting a trial de novo
2609 under Subsection (8)(o)(ii)(A).

2610 (p) (i) Upon filing a complaint for a trial de novo under Subsection (8)(o), a claim shall
2611 proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of
2612 Evidence in the district court.

2613 (ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may
2614 request a jury trial with a complaint requesting a trial de novo under Subsection (8)(o)(ii)(A).

2615 (q) (i) If the claimant, as the moving party in a trial de novo requested under
2616 Subsection (8)(o), does not obtain a verdict that is at least \$5,000 and is at least 20% greater
2617 than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

2618 (ii) If the underinsured motorist carrier, as the moving party in a trial de novo requested
2619 under Subsection (8)(o), does not obtain a verdict that is at least 20% less than the arbitration
2620 award, the underinsured motorist carrier is responsible for all of the nonmoving party's costs.

2621 (iii) Except as provided in Subsection (8)(q)(iv), the costs under this Subsection (8)(q)
2622 shall include:

2623 (A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

2624 (B) the costs of expert witnesses and depositions.

2625 (iv) An award of costs under this Subsection (8)(q) may not exceed \$2,500 unless
2626 Subsection (9)(h)(iii) applies.

2627 (r) For purposes of determining whether a party's verdict is greater or less than the
2628 arbitration award under Subsection (8)(q), a court may not consider any recovery or other relief
2629 granted on a claim for damages if the claim for damages:

2630 (i) was not fully disclosed in writing prior to the arbitration proceeding; or
2631 (ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil
2632 Procedure.

2633 (s) If a district court determines, upon a motion of the nonmoving party, that a moving
2634 party's use of the trial de novo process is filed in bad faith in accordance with Section
2635 78B-5-825, the district court may award reasonable attorney fees to the nonmoving party.

2636 (t) Nothing in this section is intended to limit a claim under another portion of an
2637 applicable insurance policy.

2638 (u) If there are multiple underinsured motorist policies, as set forth in Subsection (4),
2639 the claimant may elect to arbitrate in one hearing the claims against all the underinsured
2640 motorist carriers.

2641 (9) (a) Within 30 days after a covered person elects to submit a claim for underinsured
2642 motorist benefits to binding arbitration or files litigation, the covered person shall provide to
2643 the underinsured motorist carrier:

2644 (i) a written demand for payment of underinsured motorist coverage benefits, setting
2645 forth:

2646 (A) subject to Subsection (9)(l), the specific monetary amount of the demand,
2647 including a computation of the covered person's claimed past medical expenses, claimed past
2648 lost wages, and all other claimed past economic damages; and

2649 (B) the factual and legal basis and any supporting documentation for the demand;

2650 (ii) a written statement under oath disclosing:

2651 (A) (I) the names and last known addresses of all health care providers who have
2652 rendered health care services to the covered person that are material to the claims for which the
2653 underinsured motorist benefits are sought for a period of five years preceding the date of the
2654 event giving rise to the claim for underinsured motorist benefits up to the time the election for
2655 arbitration or litigation has been exercised; and

2656 (II) [~~whether the covered person has seen other~~] the names and last know addresses of
2657 the health care providers who have rendered health care services to the covered person, which
2658 the covered person claims are immaterial to the claims for which underinsured motorist
2659 benefits are sought, for a period of five years preceding the date of the event giving rise to the
2660 claim for underinsured motorist benefits up to the time the election for arbitration or litigation

2661 has been exercised that have not been disclosed under Subsection (9)(a)(ii)(A)(I);

2662 (B) (I) the names and last known addresses of all health insurers or other entities to
2663 whom the covered person has submitted claims for health care services or benefits material to
2664 the claims for which underinsured motorist benefits are sought, for a period of five years
2665 preceding the date of the event giving rise to the claim for underinsured motorist benefits up to
2666 the time the election for arbitration or litigation has been exercised; and

2667 (II) [~~whether the identity of any~~] the names and last known addresses of the health
2668 insurers or other entities to whom the covered person has submitted claims for health care
2669 services or benefits, which the covered person claims are immaterial to the claims for which
2670 underinsured motorist benefits are sought, for a period of five years preceding the date of the
2671 event giving rise to the claim for underinsured motorist benefits up to the time the election for
2672 arbitration or litigation have not been disclosed;

2673 (C) if lost wages, diminished earning capacity, or similar damages are claimed, all
2674 employers of the covered person for a period of five years preceding the date of the event
2675 giving rise to the claim for underinsured motorist benefits up to the time the election for
2676 arbitration or litigation has been exercised;

2677 (D) other documents to reasonably support the claims being asserted; and

2678 (E) all state and federal statutory lienholders including a statement as to whether the
2679 covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health
2680 Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act,
2681 or if the claim is subject to any other state or federal statutory liens; and

2682 (iii) signed authorizations to allow the underinsured motorist carrier to only obtain
2683 records and billings from the individuals or entities disclosed under Subsections
2684 (9)(a)(ii)(A)(I), (B)(I), and (C).

2685 (b) (i) If the underinsured motorist carrier determines that the disclosure of undisclosed
2686 health care providers or health care insurers under Subsection (9)(a)(ii) is reasonably necessary,
2687 the underinsured motorist carrier may:

2688 (A) make a request for the disclosure of the identity of the health care providers or
2689 health care insurers; and

2690 (B) make a request for authorizations to allow the underinsured motorist carrier to only
2691 obtain records and billings from the individuals or entities not disclosed.

2692 (ii) If the covered person does not provide the requested information within 10 days:

2693 (A) the covered person shall disclose, in writing, the legal or factual basis for the
2694 failure to disclose the health care providers or health care insurers; and

2695 (B) either the covered person or the underinsured motorist carrier may request the
2696 arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be
2697 provided if the covered person has elected arbitration.

2698 (iii) The time periods imposed by Subsection (9)(c)(i) are tolled pending resolution of
2699 the dispute concerning the disclosure and production of records of the health care providers or
2700 health care insurers.

2701 (c) (i) An underinsured motorist carrier that receives an election for arbitration or a
2702 notice of filing litigation and the demand for payment of underinsured motorist benefits under
2703 Subsection (9)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the
2704 demand and receipt of the items specified in Subsections (9)(a)(i) through (iii), to:

2705 (A) provide a written response to the written demand for payment provided for in
2706 Subsection (9)(a)(i);

2707 (B) except as provided in Subsection (9)(c)(i)(C), tender the amount, if any, of the
2708 underinsured motorist carrier's determination of the amount owed to the covered person; and

2709 (C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah
2710 Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's
2711 Health Insurance Act, or if the claim is subject to any other state or federal statutory liens,
2712 tender the amount, if any, of the underinsured motorist carrier's determination of the amount
2713 owed to the covered person less:

2714 (I) if the amount of the state or federal statutory lien is established, the amount of the
2715 lien; or

2716 (II) if the amount of the state or federal statutory lien is not established, two times the
2717 amount of the medical expenses subject to the state or federal statutory lien until such time as
2718 the amount of the state or federal statutory lien is established.

2719 (ii) If the amount tendered by the underinsured motorist carrier under Subsection
2720 (9)(c)(i) is the total amount of the underinsured motorist policy limits, the tendered amount
2721 shall be accepted by the covered person.

2722 (d) A covered person who receives a written response from an underinsured motorist

2723 carrier as provided for in Subsection (9)(c)(i), may:

2724 (i) elect to accept the amount tendered in Subsection (9)(c)(i) as payment in full of all
2725 underinsured motorist claims; or

2726 (ii) elect to:

2727 (A) accept the amount tendered in Subsection (9)(c)(i) as partial payment of all
2728 underinsured motorist claims; and

2729 (B) continue to litigate or arbitrate the remaining claim in accordance with the election
2730 made under Subsections (8)(a), (b), and (c).

2731 (e) If a covered person elects to accept the amount tendered under Subsection (9)(c)(i)
2732 as partial payment of all underinsured motorist claims, the final award obtained through
2733 arbitration, litigation, or later settlement shall be reduced by any payment made by the
2734 underinsured motorist carrier under Subsection (9)(c)(i).

2735 (f) In an arbitration proceeding on the remaining underinsured claims:

2736 (i) the parties may not disclose to the arbitrator or arbitration panel the amount paid
2737 under Subsection (9)(c)(i) until after the arbitration award has been rendered; and

2738 (ii) the parties may not disclose the amount of the limits of underinsured motorist
2739 benefits provided by the policy.

2740 (g) If the final award obtained through arbitration or litigation is greater than the
2741 average of the covered person's initial written demand for payment provided for in Subsection
2742 (9)(a)(i) and the underinsured motorist carrier's initial written response provided for in
2743 Subsection (9)(c)(i), the underinsured motorist carrier shall pay:

2744 (i) the final award obtained through arbitration or litigation, except that if the award
2745 exceeds the policy limits of the subject underinsured motorist policy by more than \$15,000, the
2746 amount shall be reduced to an amount equal to the policy limits plus \$15,000; and

2747 (ii) any of the following applicable costs:

2748 (A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

2749 (B) the arbitrator or arbitration panel's fee; and

2750 (C) the reasonable costs of expert witnesses and depositions used in the presentation of
2751 evidence during arbitration or litigation.

2752 (h) (i) The covered person shall provide an affidavit of costs within five days of an
2753 arbitration award.

2754 (ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to
2755 which the underinsured motorist carrier objects.

2756 (B) The objection shall be resolved by the arbitrator or arbitration panel.

2757 (iii) The award of costs by the arbitrator or arbitration panel under Subsection (9)(g)(ii)
2758 may not exceed \$5,000.

2759 (i) (i) A covered person shall disclose all material information, other than rebuttal
2760 evidence, within 30 days after a covered person elects to submit a claim for underinsured
2761 motorist coverage benefits to binding arbitration or files litigation as specified in Subsection
2762 (9)(a).

2763 (ii) If the information under Subsection (9)(i)(i) is not disclosed, the covered person
2764 may not recover costs or any amounts in excess of the policy under Subsection (9)(g).

2765 (j) This Subsection (9) does not limit any other cause of action that arose or may arise
2766 against the underinsured motorist carrier from the same dispute.

2767 (k) The provisions of this Subsection (9) only apply to motor vehicle accidents that
2768 occur on or after March 30, 2010.

2769 (l) (i) The written demand requirement in Subsection (9)(a)(i)(A) does not affect the
2770 covered person's requirement to provide a computation of any other economic damages
2771 claimed, and the one or more respondents shall have a reasonable time after the receipt of the
2772 computation of any other economic damages claimed to conduct fact and expert discovery as to
2773 any additional damages claimed. The changes made by this bill to this Subsection (9)(l) and
2774 Subsection (9)(a)(i)(A) apply to a claim submitted to binding arbitration or through litigation
2775 on or after May 13, 2014.

2776 (ii) The changes made by this bill under Subsections (9)(a)(ii)(A)(II) and (B)(II) apply
2777 to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

2778 Section 12. Section **31A-22-428** is amended to read:

2779 **31A-22-428. Interest payable on life insurance proceeds.**

2780 (1) For a life insurance policy delivered or issued for delivery in this state on or after
2781 May 5, 2008, the insurer shall pay interest on the death proceeds payable upon the death of the
2782 insured.

2783 (2) (a) Except as provided in Subsection (4), for the period beginning on the date of
2784 death and ending the day before the day described in Subsection (3)(b), interest under

2785 Subsection (1) shall accrue at a rate no less than the greater of:

2786 (i) the rate applicable to policy funds left on deposit; ~~[or]~~ and

2787 (ii) ~~[if there is no rate described in Subsection (2)(a)(i), at]~~ the Two Year Treasury
2788 Constant Maturity Rate as published by the Federal Reserve.

2789 (b) If there is no rate applicable to policy funds on deposit as stated in Subsection
2790 (2)(a)(i), then the Two Year Treasury Constant Maturity Rates as published by the Federal
2791 Reserve applies.

2792 ~~[(b)]~~ (c) The rate described in Subsection (2)(a) or (b) is the rate in effect on the day on
2793 which the death occurs.

2794 ~~[(c)]~~ (d) Interest is payable until the day on which the claim is paid.

2795 (3) (a) Unless the claim is paid and except as provided in Subsection (4), beginning on
2796 the day described in Subsection (3)(b) and ending the day on which the claim is paid, interest
2797 shall accrue at the rate in Subsection (2) plus additional interest at the rate of 10% annually.

2798 (b) Interest accrues under Subsection (3)(a) beginning with the day that is 31 days from
2799 the latest of:

2800 (i) the day on which the insurer receives proof of death;

2801 (ii) the day on which the insurer receives sufficient information to determine:

2802 (A) liability;

2803 (B) the extent of the liability; and

2804 (C) the appropriate payee legally entitled to the proceeds; and

2805 (iii) the day on which:

2806 (A) legal impediments to payment of proceeds that depend on the action of parties
2807 other than the insurer are resolved; and

2808 (B) the insurer receives sufficient evidence of the resolution of the legal impediments
2809 described in Subsection (3)(b)(iii)(A).

2810 (4) A court of competent jurisdiction may require payment of interest from the date of
2811 death to the day on which a claim is paid at a rate equal to the sum of:

2812 (a) the rate specified in Subsection (2); and

2813 (b) the legal rate identified in Subsection 15-1-1(2).

2814 Section 13. Section 31A-22-617 is amended to read:

2815 **31A-22-617. Preferred provider contract provisions.**

2816 Health insurance policies may provide for insureds to receive services or
2817 reimbursement under the policies in accordance with preferred health care provider contracts as
2818 follows:

2819 (1) Subject to restrictions under this section, [~~any~~] an insurer or third party
2820 administrator may enter into contracts with health care providers as defined in Section
2821 78B-3-403 under which the health care providers agree to supply services, at prices specified in
2822 the contracts, to persons insured by an insurer.

2823 (a) (i) A health care provider contract may require the health care provider to accept the
2824 specified payment in this Subsection (1) as payment in full, relinquishing the right to collect
2825 additional amounts from the insured person.

2826 (ii) In [~~any~~] a dispute involving a provider's claim for reimbursement, the same shall be
2827 determined in accordance with applicable law, the provider contract, the subscriber contract,
2828 and the insurer's written payment policies in effect at the time services were rendered.

2829 (iii) If the parties are unable to resolve their dispute, the matter shall be subject to
2830 binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except
2831 the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii)
2832 does not apply to the claim of a general acute hospital to the extent it is inconsistent with the
2833 hospital's provider agreement.

2834 (iv) An organization may not penalize a provider solely for pursuing a claims dispute
2835 or otherwise demanding payment for a sum believed owing.

2836 (v) If an insurer permits another entity with which it does not share common ownership
2837 or control to use or otherwise lease one or more of the organization's networks of participating
2838 providers, the organization shall ensure, at a minimum, that the entity pays participating
2839 providers in accordance with the same fee schedule and general payment policies as the
2840 organization would for that network.

2841 (b) The insurance contract may reward the insured for selection of preferred health care
2842 providers by:

2843 (i) reducing premium rates;

2844 (ii) reducing deductibles;

2845 (iii) coinsurance;

2846 (iv) other copayments; or

- 2847 (v) any other reasonable manner.
- 2848 (c) If the insurer is a managed care organization, as defined in Subsection
- 2849 31A-27a-403(1)(f):
- 2850 (i) the insurance contract and the health care provider contract shall provide that in the
- 2851 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:
- 2852 (A) require the health care provider to continue to provide health care services under
- 2853 the contract until the earlier of:
- 2854 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for
- 2855 liquidation; or
- 2856 (II) the date the term of the contract ends; and
- 2857 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to
- 2858 receive from the managed care organization during the time period described in Subsection
- 2859 (1)(c)(i)(A);
- 2860 (ii) the provider is required to:
- 2861 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
- 2862 (B) relinquish the right to collect additional amounts from the insolvent managed care
- 2863 organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);
- 2864 (iii) if the contract between the health care provider and the managed care organization
- 2865 has not been reduced to writing, or the contract fails to contain the [~~language required by~~
- 2866 requirements described in Subsection (1)(c)(i), the provider may not collect or attempt to
- 2867 collect from the enrollee:
- 2868 (A) sums owed by the insolvent managed care organization; or
- 2869 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
- 2870 (iv) the following may not bill or maintain [~~any~~] an action at law against an enrollee to
- 2871 collect sums owed by the insolvent managed care organization or the amount of the regular fee
- 2872 reduction authorized under Subsection (1)(c)(i)(B):
- 2873 (A) a provider;
- 2874 (B) an agent;
- 2875 (C) a trustee; or
- 2876 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
- 2877 (v) notwithstanding Subsection (1)(c)(i):

2878 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's
2879 regular fee set forth in the contract; and

2880 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments
2881 for services received from the provider that the enrollee was required to pay before the filing
2882 of:

2883 (I) a petition for rehabilitation; or

2884 (II) a petition for liquidation.

2885 (2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health
2886 care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on
2887 or after January 1, 2014.

2888 (b) When reimbursing for services of health care providers not under contract, the
2889 insurer may make direct payment to the insured.

2890 (c) An insurer using preferred health care provider contracts may impose a deductible
2891 on coverage of health care providers not under contract.

2892 (d) When selecting health care providers with whom to contract under Subsection (1),
2893 an insurer may not unfairly discriminate between classes of health care providers, but may
2894 discriminate within a class of health care providers, subject to Subsection (7).

2895 (e) For purposes of this section, unfair discrimination between classes of health care
2896 providers includes:

2897 (i) refusal to contract with class members in reasonable proportion to the number of
2898 insureds covered by the insurer and the expected demand for services from class members; and

2899 (ii) refusal to cover procedures for one class of providers that are:

2900 (A) commonly used by members of the class of health care providers for the treatment
2901 of illnesses, injuries, or conditions;

2902 (B) otherwise covered by the insurer; and

2903 (C) within the scope of practice of the class of health care providers.

2904 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
2905 to the insured that it has entered into preferred health care provider contracts. The insurer shall
2906 provide sufficient detail on the preferred health care provider contracts to permit the insured to
2907 agree to the terms of the insurance contract. The insurer shall provide at least the following
2908 information:

2909 (a) a list of the health care providers under contract, and if requested their business
2910 locations and specialties;

2911 (b) a description of the insured benefits, including [~~any~~] deductibles, coinsurance, or
2912 other copayments;

2913 (c) a description of the quality assurance program required under Subsection (4); and

2914 (d) a description of the adverse benefit determination procedures required under
2915 Subsection (5).

2916 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
2917 assurance program for assuring that the care provided by the health care providers under
2918 contract meets prevailing standards in the state.

2919 (b) The commissioner in consultation with the executive director of the Department of
2920 Health may designate qualified persons to perform an audit of the quality assurance program.
2921 The auditors shall have full access to all records of the organization and its health care
2922 providers, including medical records of individual patients.

2923 (c) The information contained in the medical records of individual patients shall
2924 remain confidential. All information, interviews, reports, statements, memoranda, or other data
2925 furnished for purposes of the audit and any findings or conclusions of the auditors are
2926 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
2927 proceeding except hearings before the commissioner concerning alleged violations of this
2928 section.

2929 (5) An insurer using preferred health care provider contracts shall provide a reasonable
2930 procedure for resolving complaints and adverse benefit determinations initiated by the insureds
2931 and health care providers.

2932 (6) An insurer may not contract with a health care provider for treatment of illness or
2933 injury unless the health care provider is licensed to perform that treatment.

2934 (7) (a) A health care provider or insurer may not discriminate against a preferred health
2935 care provider for agreeing to a contract under Subsection (1).

2936 (b) [~~Any~~] A health care provider licensed to treat [~~any~~] an illness or injury within the
2937 scope of the health care provider's practice, who is willing and able to meet the terms and
2938 conditions established by the insurer for designation as a preferred health care provider, shall
2939 be able to apply for and receive the designation as a preferred health care provider. Contract

2940 terms and conditions may include reasonable limitations on the number of designated preferred
2941 health care providers based upon substantial objective and economic grounds, or expected use
2942 of particular services based upon prior provider-patient profiles.

2943 (8) Upon the written request of a provider excluded from a provider contract, the
2944 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
2945 based on the criteria set forth in Subsection (7)(b).

2946 [~~(9) Except as provided in Subsection 31A-22-618.5(3)(a), insurers are subject to~~
2947 ~~Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.~~]

2948 [~~(10)~~] (9) Nothing in this section is to be construed as to require an insurer to offer a
2949 certain benefit or service as part of a health benefit plan.

2950 [~~(11)~~] (10) This section does not apply to catastrophic mental health coverage provided
2951 in accordance with Section 31A-22-625.

2952 [~~(12)~~] (11) Notwithstanding [~~the provisions of~~] Subsection (1), Subsection (7)(b), and
2953 Section 31A-22-618, an insurer or third party administrator is not required to, but may, enter
2954 into [~~contracts~~] a contract with a licensed athletic [~~trainers~~] trainer, licensed under Title 58,
2955 Chapter 40a, Athletic Trainer Licensing Act.

2956 Section 14. Section 31A-22-618.5 is amended to read:

2957 **31A-22-618.5. Health benefit plan offerings.**

2958 (1) The purpose of this section is to increase the range of health benefit plans available
2959 in the small group, small employer group, large group, and individual insurance markets.

2960 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
2961 Organizations and Limited Health Plans:

2962 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
2963 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
2964 and

2965 (b) may offer to a potential purchaser one or more health benefit plans that:

2966 (i) are not subject to one or more of the following:

2967 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

2968 (B) the limitation on point of service products in Subsections 31A-8-408(3) through

2969 (6);

2970 (C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in

2971 Section 31A-8-101; or

2972 (D) coverage mandates enacted after January 1, 2009 that are not required by federal
2973 law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate
2974 enacted after January 1, 2009; and

2975 (ii) when offering a health plan under this section, provide coverage for an emergency
2976 medical condition as required by Section 31A-22-627 as follows:

2977 (A) within the organization's service area, covered services shall include health care
2978 services from nonaffiliated providers when medically necessary to stabilize an emergency
2979 medical condition; and

2980 (B) outside the organization's service area, covered services shall include medically
2981 necessary health care services for the treatment of an emergency medical condition that are
2982 immediately required while the enrollee is outside the geographic limits of the organization's
2983 service area.

2984 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
2985 Maintenance Organizations and Limited Health Plans:

2986 (a) [~~notwithstanding Subsection 31A-22-617(9),~~] may offer a health benefit plan that is
2987 not subject to Section 31A-22-618;

2988 (b) when offering a health plan under this Subsection (3), shall provide coverage of
2989 emergency care services as required by Section 31A-22-627; and

2990 (c) is not subject to coverage mandates enacted after January 1, 2009 that are not
2991 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
2992 after January 1, 2009.

2993 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under
2994 Subsection (2)(b).

2995 (5) (a) Any difference in price between a health benefit plan offered under Subsections
2996 (2)(a) and (b) shall be based on actuarially sound data.

2997 (b) Any difference in price between a health benefit plan offered under Subsection
2998 (3)(a) shall be based on actuarially sound data.

2999 (6) Nothing in this section limits the number of health benefit plans that an insurer may
3000 offer.

3001 Section 15. Section 31A-22-625 is amended to read:

3002 **31A-22-625. Catastrophic coverage of mental health conditions.**

3003 (1) As used in this section:

3004 (a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan
3005 that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or
3006 outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden
3007 on an insured for the evaluation and treatment of a mental health condition than for the
3008 evaluation and treatment of a physical health condition.

3009 (ii) "Catastrophic mental health coverage" may include a restriction on cost sharing
3010 factors, such as deductibles, copayments, or coinsurance, before reaching a maximum
3011 out-of-pocket limit.

3012 (iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket
3013 limit for physical health conditions and another maximum out-of-pocket limit for mental health
3014 conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit
3015 for mental health conditions may not exceed the out-of-pocket limit for physical health
3016 conditions.

3017 (b) (i) "50/50 mental health coverage" means coverage in a health benefit plan that
3018 pays for at least 50% of covered services for the diagnosis and treatment of mental health
3019 conditions.

3020 (ii) "50/50 mental health coverage" may include a restriction on:

3021 (A) episodic limits;

3022 (B) inpatient or outpatient service limits; or

3023 (C) maximum out-of-pocket limits.

3024 (c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

3025 (d) (i) "Mental health condition" means a condition or disorder involving mental illness
3026 that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as
3027 periodically revised.

3028 (ii) "Mental health condition" does not include the following when diagnosed as the
3029 primary or substantial reason or need for treatment:

3030 (A) a marital or family problem;

3031 (B) a social, occupational, religious, or other social maladjustment;

3032 (C) a conduct disorder;

- 3033 (D) a chronic adjustment disorder;
- 3034 (E) a psychosexual disorder;
- 3035 (F) a chronic organic brain syndrome;
- 3036 (G) a personality disorder;
- 3037 (H) a specific developmental disorder or learning disability; or
- 3038 (I) an intellectual disability.
- 3039 (e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.
- 3040 (2) (a) At the time of purchase and renewal, an insurer shall offer to a small employer
- 3041 that it insures or seeks to insure a choice between:
- 3042 (i) (A) catastrophic mental health coverage; or
- 3043 (B) federally qualified mental health coverage as described in Subsection (3); and
- 3044 (ii) 50/50 mental health coverage.
- 3045 (b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:
- 3046 (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels
- 3047 that exceed the minimum requirements of this section; or
- 3048 (ii) coverage that excludes benefits for mental health conditions.
- 3049 (c) A small employer may, at its option, regardless of the employer's previous coverage
- 3050 for mental health conditions, choose either:
- 3051 (i) coverage offered under Subsection (2)(a)(i);
- 3052 (ii) 50/50 mental health coverage; or
- 3053 (iii) coverage offered under Subsection (2)(b).
- 3054 (d) An insurer is exempt from the 30% index rating restriction in Section
- 3055 [31A-30-106.1](#) and, for the first year only that the employer chooses coverage that meets or
- 3056 exceeds catastrophic mental health coverage, the 15% annual adjustment restriction in Section
- 3057 [31A-30-106.1](#), for ~~any~~ a small employer with 20 or less enrolled employees who chooses
- 3058 coverage that meets or exceeds catastrophic mental health coverage.
- 3059 (3) (a) An insurer shall offer a large employer mental health and substance use disorder
- 3060 benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec.
- 3061 300gg-26, and federal regulations adopted pursuant to that act.
- 3062 (b) An insurer shall provide in an individual or small employer health benefit plan,
- 3063 mental health and substance use disorder benefits in compliance with Sections 2705 and 2711

3064 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted
3065 pursuant to that act.

3066 (4) (a) An insurer may provide catastrophic mental health coverage to a small employer
3067 through a managed care organization or system in a manner consistent with Chapter 8, Health
3068 Maintenance Organizations and Limited Health Plans, regardless of whether the insurance
3069 policy uses a managed care organization or system for the treatment of physical health
3070 conditions.

3071 (b) (i) Notwithstanding any other provision of this title, an insurer may:

3072 (A) establish a closed panel of providers for catastrophic mental health coverage; and

3073 (B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider

3074 unless:

3075 (I) the insured is referred to a nonpanel provider with the prior authorization of the
3076 insurer; and

3077 (II) the nonpanel provider agrees to follow the insurer's protocols and treatment
3078 guidelines.

3079 (ii) If an insured receives services from a nonpanel provider in the manner permitted by
3080 Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the
3081 average amount paid by the insurer for comparable services of panel providers under a
3082 noncapitated arrangement who are members of the same class of health care providers.

3083 (iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a
3084 referral to a nonpanel provider.

3085 (c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a
3086 mental health condition shall be rendered:

3087 (i) by a mental health therapist as defined in Section [58-60-102](#); or

3088 (ii) in a health care facility:

3089 (A) licensed or otherwise authorized to provide mental health services pursuant to:

3090 (I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

3091 (II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and

3092 (B) that provides a program for the treatment of a mental health condition pursuant to a
3093 written plan.

3094 (5) The commissioner may prohibit an insurance policy that provides mental health

3095 coverage in a manner that is inconsistent with this section.

3096 (6) The commissioner [~~shall: (a)~~] may adopt rules, in accordance with Title 63G,
3097 Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this
3098 section[~~; and~~].

3099 [~~(b) provide general figures on the percentage of insurance policies that include:~~]

3100 [~~(i) no mental health coverage;~~]

3101 [~~(ii) 50/50 mental health coverage;~~]

3102 [~~(iii) catastrophic mental health coverage; and~~]

3103 [~~(iv) coverage that exceeds the minimum requirements of this section.~~]

3104 [~~(7) This section may not be construed as discouraging or otherwise preventing an~~
3105 ~~insurer from providing mental health coverage in connection with an individual insurance~~
3106 ~~policy.~~]

3107 Section 16. Section **31A-22-635** is amended to read:

3108 **31A-22-635. Uniform application -- Uniform waiver of coverage -- Information**
3109 **on Health Insurance Exchange.**

3110 (1) For purposes of this section, "insurer":

3111 (a) is defined in Subsection [31A-22-634\(1\)](#); and

3112 (b) includes the state employee's risk pool under Section [49-20-202](#).

3113 (2) (a) Insurers offering a health benefit plan to an individual or small employer shall
3114 use a uniform application form.

3115 (b) The uniform application form:

3116 (i) [~~except for cancer and transplants;~~] may not include questions about an applicant's
3117 health history [~~prior to the previous five years~~]; and

3118 (ii) shall be shortened and simplified in accordance with rules adopted by the
3119 commissioner.

3120 (c) Insurers offering a health benefit plan to a small employer shall use a uniform
3121 waiver of coverage form, which may not include health status related questions [~~other than~~
3122 ~~pregnancy~~], and is limited to:

3123 (i) information that identifies the employee;

3124 (ii) proof of the employee's insurance coverage; and

3125 (iii) a statement that the employee declines coverage with a particular employer group.

3126 (3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and
3127 uniform waiver of coverage forms may, if the combination or modification is approved by the
3128 commissioner, be combined or modified to facilitate a more efficient and consumer friendly
3129 experience for:

- 3130 (a) enrollees using the Health Insurance Exchange; or
- 3131 (b) insurers using electronic applications.

3132 (4) The uniform application form, and uniform waiver form, shall be adopted and
3133 approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative
3134 Rulemaking Act.

3135 (5) (a) An insurer who offers a health benefit plan [~~in either the group or individual~~
3136 ~~market~~] on the Health Insurance Exchange created in Section 63M-1-2504, shall:

3137 (i) accept and process an electronic submission of the uniform application or uniform
3138 waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to
3139 Section 63M-1-2506;

3140 (ii) if requested, provide the applicant with a copy of the completed application either
3141 by mail or electronically;

3142 (iii) post all health benefit plans offered by the insurer in the defined contribution
3143 arrangement market on the Health Insurance Exchange; and

3144 (iv) post the information required by Subsection (6) on the Health Insurance Exchange
3145 for every health benefit plan the insurer offers on the Health Insurance Exchange.

3146 (b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans
3147 on the Health Insurance Exchange may not directly or indirectly offer products on the Health
3148 Insurance Exchange that are not health benefit plans.

3149 (c) Notwithstanding Subsection (5)(b):

3150 (i) an insurer may offer a health savings account on the Health Insurance Exchange;
3151 [~~and~~]

3152 (ii) an insurer may offer dental [~~and vision~~] plans on the Health Insurance Exchange
3153 [~~if~~]; and

3154 [~~(A) the department determines, after study and consultation with the Health System~~
3155 ~~Reform Task Force, that the department is able to establish standards for dental and vision~~
3156 ~~policies offered on the Health Insurance Exchange, and the department determines whether a~~

3157 risk adjuster mechanism is necessary for a defined contribution vision and dental plan market
3158 on the Health Insurance Exchange; and]

3159 [(B)] (iii) the department[, in accordance with recommendations from the Health
3160 System Reform Task Force, adopts] may make administrative rules to regulate the offer of
3161 dental [~~and vision~~] plans on the Health Insurance Exchange.

3162 (6) An insurer shall provide the commissioner and the Health Insurance Exchange with
3163 the following information for each health benefit plan submitted to the Health Insurance
3164 Exchange, in the electronic format required by Subsection 63M-1-2506(1):

3165 (a) plan design, benefits, and options offered by the health benefit plan including state
3166 mandates the plan does not cover;

3167 (b) information and Internet address to online provider networks;

3168 (c) wellness programs and incentives;

3169 (d) descriptions of prescription drug benefits, exclusions, or limitations;

3170 (e) the percentage of claims paid by the insurer within 30 days of the date a claim is
3171 submitted to the insurer for the prior year; and

3172 (f) the claims denial and insurer transparency information developed in accordance
3173 with Subsection 31A-22-613.5(4).

3174 (7) The department shall post on the Health Insurance Exchange the department's
3175 solvency rating for each insurer who posts a health benefit plan on the Health Insurance
3176 Exchange. The solvency rating for each insurer shall be based on methodology established by
3177 the department by administrative rule and shall be updated each calendar year.

3178 (8) (a) The commissioner may request information from an insurer under Section
3179 31A-22-613.5 to verify the data submitted to the department and to the Health Insurance
3180 Exchange.

3181 (b) The commissioner shall regulate [~~any~~] the fees charged by insurers to an enrollee
3182 for a uniform application form or electronic submission of the application forms.

3183 Section 17. Section 31A-22-721 is amended to read:

3184 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**
3185 **nonrenewal.**

3186 (1) Except as otherwise provided in this section, a health benefit plan for a plan
3187 sponsor is renewable and continues in force:

- 3188 (a) with respect to all eligible employees and dependents; and
- 3189 (b) at the option of the plan sponsor.
- 3190 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:
- 3191 (a) for a network plan, if~~[(i)]~~ there is no longer any enrollee under the group health
- 3192 plan who lives, resides, or works in:
 - 3193 ~~[(A)]~~ (i) the service area of the insurer; or
 - 3194 ~~[(B)]~~ (ii) the area for which the insurer is authorized to do business; ~~[and] or~~
 - 3195 ~~[(ii) in the case of the small employer market, the insurer applies the same criteria the~~
 - 3196 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or]~~
- 3197 (b) for coverage made available in the small or large employer market only through an
- 3198 association, if:
 - 3199 (i) the employer's membership in the association ceases; and
 - 3200 (ii) the coverage is terminated uniformly without regard to any health status-related
 - 3201 factor relating to any covered individual.
- 3202 (3) A health benefit plan for a plan sponsor may be discontinued if:
- 3203 (a) a condition described in Subsection (2) exists;
- 3204 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
- 3205 terms of the contract;
- 3206 (c) the plan sponsor:
 - 3207 (i) performs an act or practice that constitutes fraud; or
 - 3208 (ii) makes an intentional misrepresentation of material fact under the terms of the
 - 3209 coverage;
- 3210 (d) the insurer:
 - 3211 (i) elects to discontinue offering a particular health benefit product delivered or issued
 - 3212 for delivery in this state;
 - 3213 (ii) (A) provides notice of the discontinuation in writing:
 - 3214 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
 - 3215 (II) at least 90 days before the date the coverage will be discontinued;
 - 3216 (B) provides notice of the discontinuation in writing:
 - 3217 (I) to the commissioner; and
 - 3218 (II) at least three working days prior to the date the notice is sent to the affected plan

- 3219 sponsors, employees, and dependents of plan sponsors or employees;
- 3220 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
- 3221 other health benefit products currently being offered:
- 3222 (I) by the insurer in the market; or
- 3223 (II) in the case of a large employer, any other health benefit plan currently being
- 3224 offered in that market; and
- 3225 (D) in exercising the option to discontinue that product and in offering the option of
- 3226 coverage in this section, the insurer acts uniformly without regard to:
- 3227 (I) the claims experience of a plan sponsor;
- 3228 (II) any health status-related factor relating to any covered participant or beneficiary; or
- 3229 (III) any health status-related factor relating to a new participant or beneficiary who
- 3230 may become eligible for coverage; or
- 3231 (e) the insurer:
- 3232 (i) elects to discontinue all of the insurer's health benefit plans:
- 3233 (A) in the small employer market; or
- 3234 (B) the large employer market; or
- 3235 (C) both the small and large employer markets; and
- 3236 (ii) (A) provides notice of the discontinuance in writing:
- 3237 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
- 3238 (II) at least 180 days before the date the coverage will be discontinued;
- 3239 (B) provides notice of the discontinuation in writing:
- 3240 (I) to the commissioner in each state in which an affected insured individual is known
- 3241 to reside; and
- 3242 (II) at least 30 business days prior to the date the notice is sent to the affected plan
- 3243 sponsors, employees, and dependents of a plan sponsor or employee;
- 3244 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
- 3245 market; and
- 3246 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
- 3247 (4) A large employer health benefit plan may be discontinued or nonrenewed:
- 3248 (a) if a condition described in Subsection (2) exists; or
- 3249 (b) for noncompliance with the insurer's:

- 3250 (i) minimum participation requirements; or
- 3251 (ii) employer contribution requirements.
- 3252 (5) A small employer health benefit plan may be discontinued or nonrenewed:
- 3253 (a) if a condition described in Subsection (2) exists; or
- 3254 (b) for noncompliance with the insurer's employer contribution requirements.
- 3255 (6) A small employer health benefit plan may be nonrenewed:
- 3256 (a) if a condition described in Subsection (2) exists; or
- 3257 (b) for noncompliance with the insurer's minimum participation requirements.
- 3258 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
- 3259 discontinued if after issuance of coverage the eligible employee:
- 3260 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
- 3261 or
- 3262 (ii) makes an intentional misrepresentation of material fact in connection with the
- 3263 coverage.
- 3264 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
- 3265 (i) 12 months after the date of discontinuance; and
- 3266 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
- 3267 to reenroll.
- 3268 (c) At the time the eligible employee's coverage is discontinued under Subsection
- 3269 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
- 3270 discontinued.
- 3271 (d) An eligible employee may not be discontinued under this Subsection (7) because of
- 3272 a fraud or misrepresentation that relates to health status.
- 3273 (8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue
- 3274 offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new
- 3275 business in such market in this state for a period of five years beginning on the date of
- 3276 discontinuation of the last coverage that is discontinued.
- 3277 (b) The commissioner may waive the prohibition under Subsection (8)(a) when the
- 3278 commissioner finds that waiver is in the public interest:
- 3279 (i) to promote competition; or
- 3280 (ii) to resolve inequity in the marketplace.

3281 (9) If an insurer is doing business in one established geographic service area of the
3282 state, this section applies only to the insurer's operations in that geographic service area.

3283 (10) An insurer may modify a health benefit plan for a plan sponsor only:

3284 (a) at the time of coverage renewal; and

3285 (b) if the modification is effective uniformly among all plans with a particular product
3286 or service.

3287 (11) For purposes of this section, a reference to "plan sponsor" includes a reference to
3288 the employer:

3289 (a) with respect to coverage provided to an employer member of the association; and

3290 (b) if the health benefit plan is made available by an insurer in the employer market
3291 only through:

3292 (i) an association;

3293 (ii) a trust; or

3294 (iii) a discretionary group.

3295 (12) (a) A small employer that, after purchasing a health benefit plan in the small group
3296 market, employs on average more than 50 eligible employees on each business day in a
3297 calendar year may continue to renew the health benefit plan purchased in the small group
3298 market.

3299 (b) A large employer that, after purchasing a health benefit plan in the large group
3300 market, employs on average less than 51 eligible employees on each business day in a calendar
3301 year may continue to renew the health benefit plan purchased in the large group market.

3302 (13) An insurer offering employer sponsored health benefit plans shall comply with the
3303 Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.

3304 Section 18. Section **31A-23a-102** is amended to read:

3305 **31A-23a-102. Definitions.**

3306 As used in this chapter:

3307 (1) "Bail bond producer" is as defined in Section [31A-35-102](#).

3308 (2) "Home state" means a state or territory of the United States or the District of
3309 Columbia in which an insurance producer:

3310 (a) maintains the insurance producer's principal:

3311 (i) place of residence; or

- 3312 (ii) place of business; and
- 3313 (b) is licensed to act as an insurance producer.
- 3314 (3) "Insurer" is as defined in Section 31A-1-301, except that the following persons or
- 3315 similar persons are not insurers for purposes of Part 7, Producer Controlled Insurers:
- 3316 (a) a risk retention group as defined in:
- 3317 (i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;
- 3318 (ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and
- 3319 (iii) Chapter 15, Part 2, Risk Retention Groups Act;
- 3320 (b) a residual market pool;
- 3321 (c) a joint underwriting authority or association; and
- 3322 (d) a captive insurer.
- 3323 (4) "License" is defined in Section 31A-1-301.
- 3324 (5) (a) "Managing general agent" means a person that:
- 3325 (i) manages all or part of the insurance business of an insurer, including the
- 3326 management of a separate division, department, or underwriting office;
- 3327 (ii) acts as an agent for the insurer whether it is known as a managing general agent,
- 3328 manager, or other similar term;
- 3329 (iii) produces and underwrites an amount of gross direct written premium equal to, or
- 3330 more than, 5% of[;] the policyholder surplus as reported in the last annual statement of the
- 3331 insurer in any one quarter or year:
- 3332 (A) with or without the authority;
- 3333 (B) separately or together with an affiliate; and
- 3334 (C) directly or indirectly; and
- 3335 (iv) (A) adjusts or pays claims in excess of an amount determined by the
- 3336 commissioner; or
- 3337 (B) negotiates reinsurance on behalf of the insurer.
- 3338 (b) Notwithstanding Subsection (5)(a), the following persons may not be considered as
- 3339 managing general agent for the purposes of this chapter:
- 3340 (i) an employee of the insurer;
- 3341 (ii) a United States manager of the United States branch of an alien insurer;
- 3342 (iii) an underwriting manager that, pursuant to contract:

- 3343 (A) manages all the insurance operations of the insurer;
- 3344 (B) is under common control with the insurer;
- 3345 (C) is subject to Chapter 16, Insurance Holding Companies; and
- 3346 (D) is not compensated based on the volume of premiums written; and
- 3347 (iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal
- 3348 insurer or inter-insurance exchange under powers of attorney.
- 3349 (6) "Negotiate" means the act of conferring directly with or offering advice directly to a
- 3350 purchaser or prospective purchaser of a particular contract of insurance concerning a
- 3351 substantive benefit, term, or condition of the contract if the person engaged in that act:
- 3352 (a) sells insurance; or
- 3353 (b) obtains insurance from insurers for purchasers.
- 3354 (7) "Reinsurance intermediary" means:
- 3355 (a) a reinsurance intermediary-broker; or
- 3356 (b) a reinsurance intermediary-manager.
- 3357 (8) "Reinsurance intermediary-broker" means a person other than an officer or
- 3358 employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or
- 3359 places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority
- 3360 or power to bind reinsurance on behalf of the insurer.
- 3361 (9) (a) "Reinsurance intermediary-manager" means a person who:
- 3362 (i) has authority to bind or who manages all or part of the assumed reinsurance
- 3363 business of a reinsurer, including the management of a separate division, department, or
- 3364 underwriting office; and
- 3365 (ii) acts as an agent for the reinsurer whether the person is known as a reinsurance
- 3366 intermediary-manager, manager, or other similar term.
- 3367 (b) Notwithstanding Subsection (9)(a), the following persons may not be considered
- 3368 reinsurance intermediary-managers for the purpose of this chapter with respect to the reinsurer:
- 3369 (i) an employee of the reinsurer;
- 3370 (ii) a United States manager of the United States branch of an alien reinsurer;
- 3371 (iii) an underwriting manager that, pursuant to contract:
- 3372 (A) manages all the reinsurance operations of the reinsurer;
- 3373 (B) is under common control with the reinsurer;

- 3374 (C) is subject to Chapter 16, Insurance Holding Companies; and
- 3375 (D) is not compensated based on the volume of premiums written; and
- 3376 (iv) the manager of a group, association, pool, or organization of insurers that:
- 3377 (A) engage in joint underwriting or joint reinsurance; and
- 3378 (B) are subject to examination by the insurance commissioner of the state in which the
- 3379 manager's principal business office is located.

3380 (10) "Resident" is as defined by rule made by the commissioner in accordance with

3381 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3382 [~~(10)~~] (11) "Search" means a license subline of authority in conjunction with the title

3383 insurance line of authority that allows a person to issue title insurance commitments or policies

3384 on behalf of a title insurer.

3385 [~~(11)~~] (12) "Sell" means to exchange a contract of insurance:

- 3386 (a) by any means;
- 3387 (b) for money or its equivalent; and
- 3388 (c) on behalf of an insurance company.

3389 [~~(12)~~] (13) "Solicit" means:

- 3390 (a) attempting to sell insurance;
- 3391 (b) asking or urging a person to apply for:
 - 3392 (i) a particular kind of insurance; and
 - 3393 (ii) insurance from a particular insurance company;
- 3394 (c) advertising insurance, including advertising for the purpose of obtaining leads for
- 3395 the sale of insurance; or
- 3396 (d) holding oneself out as being in the insurance business.

3397 [~~(13)~~] (14) "Terminate" means:

- 3398 (a) the cancellation of the relationship between:
 - 3399 (i) an individual licensee or agency licensee and a particular insurer; or
 - 3400 (ii) an individual licensee and a particular agency licensee; or
- 3401 (b) the termination of:
 - 3402 (i) an individual licensee's or agency licensee's authority to transact insurance on behalf
 - 3403 of a particular insurance company; or
 - 3404 (ii) an individual licensee's authority to transact insurance on behalf of a particular

3405 agency licensee.

3406 [~~(14)~~] (15) "Title marketing representative" means a person who:

3407 (a) represents a title insurer in soliciting, requesting, or negotiating the placing of:

3408 (i) title insurance; or

3409 (ii) escrow services; and

3410 (b) does not have a search or escrow license as provided in Section [31A-23a-106](#).

3411 [~~(15)~~] (16) "Uniform application" means the version of the National Association of
3412 Insurance Commissioners' uniform application for resident and nonresident producer licensing
3413 at the time the application is filed.

3414 [~~(16)~~] (17) "Uniform business entity application" means the version of the National
3415 Association of Insurance Commissioners' uniform business entity application for resident and
3416 nonresident business entities at the time the application is filed.

3417 Section 19. Section **31A-23a-104** is amended to read:

3418 **31A-23a-104. Application for individual license -- Application for agency license.**

3419 (1) This section applies to an initial or renewal license as a:

3420 (a) producer;

3421 (b) surplus lines producer;

3422 (c) limited line producer;

3423 (d) consultant;

3424 (e) managing general agent; or

3425 (f) reinsurance intermediary.

3426 (2) (a) Subject to Subsection (2)(b), to obtain or renew an individual license, an
3427 individual shall:

3428 (i) file an application for an initial or renewal individual license with the commissioner
3429 on forms and in a manner the commissioner prescribes; and

3430 (ii) pay a license fee that is not refunded if the application:

3431 (A) is denied; or

3432 (B) is incomplete when filed and is never completed by the applicant.

3433 (b) An application described in this Subsection (2) shall provide:

3434 (i) information about the applicant's identity;

3435 (ii) the applicant's Social Security number;

- 3436 (iii) the applicant's personal history, experience, education, and business record;
- 3437 (iv) whether the applicant is 18 years of age or older;
- 3438 (v) whether the applicant has committed an act that is a ground for denial, suspension,
- 3439 or revocation as set forth in Section 31A-23a-105 or 31A-23a-111;
- 3440 (vi) if the application is for a resident individual producer license, certification that the
- 3441 applicant complies with Section 31A-23a-203.5; and

3442 (vii) any other information the commissioner reasonably requires.

3443 (3) The commissioner may require a document reasonably necessary to verify the

3444 information contained in an application filed under this section.

3445 (4) An applicant's Social Security number contained in an application filed under this

3446 section is a private record under Section 63G-2-302.

3447 (5) (a) Subject to Subsection (5)(b), to obtain or renew an agency license, a person

3448 shall:

3449 (i) file an application for an initial or renewal agency license with the commissioner on

3450 forms and in a manner the commissioner prescribes; and

3451 (ii) pay a license fee that is not refunded if the application:

3452 (A) is denied; or

3453 (B) is incomplete when filed and is never completed by the applicant.

3454 (b) An application described in Subsection (5)(a) shall provide:

3455 (i) information about the applicant's identity;

3456 (ii) the applicant's federal employer identification number;

3457 (iii) the designated responsible licensed [~~producer~~] individual;

3458 (iv) the identity of the owners, partners, officers, and directors;

3459 (v) whether the applicant has committed an act that is a ground for denial, suspension,

3460 or revocation as set forth in Section 31A-23a-105 or 31A-23a-111; and

3461 (vi) any other information the commissioner reasonably requires.

3462 Section 20. Section 31A-23a-105 is amended to read:

3463 **31A-23a-105. General requirements for individual and agency license issuance**

3464 **and renewal.**

3465 (1) (a) The commissioner shall issue or renew a license to a person described in

3466 Subsection (1)(b) to act as:

- 3467 (i) a producer;
- 3468 (ii) a surplus lines producer;
- 3469 (iii) a limited line producer;
- 3470 (iv) a consultant;
- 3471 (v) a managing general agent; or
- 3472 (vi) a reinsurance intermediary.
- 3473 (b) The commissioner shall issue or renew a license under Subsection (1)(a) to a
- 3474 person who, as to the license type and line of authority classification applied for under Section
- 3475 [31A-23a-106](#):
- 3476 (i) satisfies the application requirements under Section [31A-23a-104](#);
- 3477 (ii) satisfies the character requirements under Section [31A-23a-107](#);
- 3478 (iii) satisfies [~~any~~] applicable continuing education requirements under Section
- 3479 [31A-23a-202](#);
- 3480 (iv) satisfies [~~any~~] applicable examination requirements under Section [31A-23a-108](#);
- 3481 (v) satisfies [~~any~~] applicable training period requirements under Section [31A-23a-203](#);
- 3482 (vi) if an applicant for a resident individual producer license, certifies that, to the extent
- 3483 applicable, the applicant:
- 3484 (A) is in compliance with Section [31A-23a-203.5](#); and
- 3485 (B) will maintain compliance with Section [31A-23a-203.5](#) during the period for which
- 3486 the license is issued or renewed;
- 3487 (vii) has not committed an act that is a ground for denial, suspension, or revocation as
- 3488 provided in Section [31A-23a-111](#);
- 3489 (viii) if a nonresident:
- 3490 (A) complies with Section [31A-23a-109](#); and
- 3491 (B) holds an active similar license in that person's home state [~~of residence~~];
- 3492 (ix) if an applicant for an individual title insurance producer or agency title insurance
- 3493 producer license, satisfies the requirements of Section [31A-23a-204](#);
- 3494 (x) if an applicant for a license to act as a life settlement provider or life settlement
- 3495 producer, satisfies the requirements of Section [31A-23a-117](#); and
- 3496 (xi) pays the applicable fees under Section [31A-3-103](#).
- 3497 (2) (a) This Subsection (2) applies to the following persons:

- 3498 (i) an applicant for a pending:
- 3499 (A) individual or agency producer license;
- 3500 (B) surplus lines producer license;
- 3501 (C) limited line producer license;
- 3502 (D) consultant license;
- 3503 (E) managing general agent license; or
- 3504 (F) reinsurance intermediary license; or
- 3505 (ii) a licensed:
- 3506 (A) individual or agency producer;
- 3507 (B) surplus lines producer;
- 3508 (C) limited line producer;
- 3509 (D) consultant;
- 3510 (E) managing general agent; or
- 3511 (F) reinsurance intermediary.
- 3512 (b) A person described in Subsection (2)(a) shall report to the commissioner:
- 3513 (i) an administrative action taken against the person, including a denial of a new or
- 3514 renewal license application:
- 3515 (A) in another jurisdiction; or
- 3516 (B) by another regulatory agency in this state; and
- 3517 (ii) a criminal prosecution taken against the person in any jurisdiction.
- 3518 (c) The report required by Subsection (2)(b) shall:
- 3519 (i) be filed:
- 3520 (A) at the time the person files the application for an individual or agency license; and
- 3521 (B) for an action or prosecution that occurs on or after the day on which the person
- 3522 files the application:
- 3523 (I) for an administrative action, within 30 days of the final disposition of the
- 3524 administrative action; or
- 3525 (II) for a criminal prosecution, within 30 days of the initial appearance before a court;
- 3526 and
- 3527 (ii) include a copy of the complaint or other relevant legal documents related to the
- 3528 action or prosecution described in Subsection (2)(b).

3529 (3) (a) The department may require a person applying for a license or for consent to
3530 engage in the business of insurance to submit to a criminal background check as a condition of
3531 receiving a license or consent.

3532 (b) A person, if required to submit to a criminal background check under Subsection
3533 (3)(a), shall:

3534 (i) submit a fingerprint card in a form acceptable to the department; and

3535 (ii) consent to a fingerprint background check by:

3536 (A) the Utah Bureau of Criminal Identification; and

3537 (B) the Federal Bureau of Investigation.

3538 (c) For a person who submits a fingerprint card and consents to a fingerprint
3539 background check under Subsection (3)(b), the department may request:

3540 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part
3541 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

3542 (ii) complete Federal Bureau of Investigation criminal background checks through the
3543 national criminal history system.

3544 (d) Information obtained by the department from the review of criminal history records
3545 received under this Subsection (3) shall be used by the department for the purposes of:

3546 (i) determining if a person satisfies the character requirements under Section
3547 [31A-23a-107](#) for issuance or renewal of a license;

3548 (ii) determining if a person has failed to maintain the character requirements under
3549 Section [31A-23a-107](#); and

3550 (iii) preventing a person who violates the federal Violent Crime Control and Law
3551 Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in
3552 the state.

3553 (e) If the department requests the criminal background information, the department
3554 shall:

3555 (i) pay to the Department of Public Safety the costs incurred by the Department of
3556 Public Safety in providing the department criminal background information under Subsection
3557 (3)(c)(i);

3558 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
3559 of Investigation in providing the department criminal background information under

3560 Subsection (3)(c)(ii); and
3561 (iii) charge the person applying for a license or for consent to engage in the business of
3562 insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).
3563 (4) To become a resident licensee in accordance with Section 31A-23a-104 and this
3564 section, a person licensed as one of the following in another state who moves to this state shall
3565 apply within 90 days of establishing legal residence in this state:
3566 (a) insurance producer;
3567 (b) surplus lines producer;
3568 (c) limited line producer;
3569 (d) consultant;
3570 (e) managing general agent; or
3571 (f) reinsurance intermediary.
3572 (5) (a) The commissioner may deny a license application for a license listed in
3573 Subsection (5)(b) if the person applying for the license, as to the license type and line of
3574 authority classification applied for under Section 31A-23a-106:
3575 (i) fails to satisfy the requirements as set forth in this section; or
3576 (ii) commits an act that is grounds for denial, suspension, or revocation as set forth in
3577 Section 31A-23a-111.
3578 (b) This Subsection (5) applies to the following licenses:
3579 (i) producer;
3580 (ii) surplus lines producer;
3581 (iii) limited line producer;
3582 (iv) consultant;
3583 (v) managing general agent; or
3584 (vi) reinsurance intermediary.
3585 (6) Notwithstanding the other provisions of this section, the commissioner may:
3586 (a) issue a license to an applicant for a license for a title insurance line of authority only
3587 with the concurrence of the Title and Escrow Commission; and
3588 (b) renew a license for a title insurance line of authority only with the concurrence of
3589 the Title and Escrow Commission.
3590 Section 21. Section 31A-23a-108 is amended to read:

3591 **31A-23a-108. Examination requirements.**

3592 (1) (a) The commissioner may require [~~applicants~~] an applicant for [~~any~~] a particular
3593 license type under Section 31A-23a-106 to pass a line of authority examination as a
3594 requirement for a license, except that an examination may not be required of [~~applicants~~] an
3595 applicant for:

3596 (i) [~~licenses~~] a license under Subsection 31A-23a-106(2)(c); or

3597 (ii) [~~other~~] another limited line license [~~lines~~] line of authority recognized by the
3598 commissioner or the Title and Escrow Commission by rule as provided in Subsection
3599 31A-23a-106(3).

3600 (b) The examination described in Subsection (1)(a):

3601 (i) shall reasonably relate to the line of authority for which it is prescribed; and

3602 (ii) may be administered by the commissioner or as otherwise specified by rule.

3603 (2) The commissioner shall waive the requirement of an examination for a nonresident
3604 applicant who:

3605 (a) applies for an insurance producer license in this state within 90 days of establishing
3606 legal residence in this state;

3607 (b) has been licensed for the same line of authority in another state; and

3608 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
3609 applies for an insurance producer license in this state; or

3610 (ii) if the application is received within 90 days of the cancellation of the applicant's
3611 previous license:

3612 (A) the prior state certifies that at the time of cancellation, the applicant was in good
3613 standing in that state; or

3614 (B) the state's producer database records maintained by the National Association of
3615 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
3616 subsidiaries, indicates that the producer is or was licensed in good standing for the line of
3617 authority requested.

3618 [~~(3) A nonresident producer licensee who moves to this state and applies for a resident~~
3619 ~~license within 90 days of establishing legal residence in this state shall be exempt from any line~~
3620 ~~of authority examination that the producer was authorized on the producer's nonresident~~
3621 ~~producer license, except where the commissioner determines otherwise by rule.]~~

3622 ~~[(4)]~~ (3) This section's requirement may only be applied to ~~[applicants who are natural~~
3623 ~~persons]~~ an applicant who is a natural person.

3624 Section 22. Section **31A-23a-112** is amended to read:

3625 **31A-23a-112. Probation -- Grounds for revocation.**

3626 (1) The commissioner may place a licensee on probation for a period not to exceed 24
3627 months as follows:

3628 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
3629 Procedures Act, for ~~[any]~~ circumstances that would justify a suspension under Section
3630 31A-23a-111; or

3631 (b) at the issuance or renewal of a ~~[new]~~ license:

3632 (i) with an admitted violation under 18 U.S.C. ~~[Sections]~~ Sec. 1033 ~~[and 1034]~~; or

3633 (ii) with a response to background information questions on a new or renewal license
3634 application ~~[indicating that]~~ or information received from a background check conducted in
3635 connection with a new or renewal license application that indicates:

3636 (A) the person has been convicted of a crime, that is listed by rule made in accordance
3637 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for
3638 probation;

3639 (B) the person is currently charged with a crime, that is listed by rule made in
3640 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
3641 grounds for probation regardless of whether adjudication is withheld;

3642 (C) the person has been involved in an administrative proceeding regarding ~~[any]~~ a
3643 professional or occupational license; or

3644 (D) ~~[any]~~ a business in which the person is or was an owner, partner, officer, or
3645 director has been involved in an administrative proceeding regarding ~~[any]~~ a professional or
3646 occupational license.

3647 (2) The commissioner may place a licensee on probation for a specified period no
3648 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. ~~[Sections]~~
3649 Sec. 1033 ~~[and 1034]~~.

3650 (3) The probation order shall state the conditions for retention of the license, which
3651 shall be reasonable.

3652 (4) ~~[Any]~~ A violation of the probation is grounds for revocation pursuant to ~~[any]~~ a

3653 proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

3654 Section 23. Section **31A-23a-113** is amended to read:

3655 **31A-23a-113. License lapse and voluntary surrender.**

3656 (1) (a) A license issued under this chapter shall lapse if the licensee fails to:

3657 (i) pay when due a fee under Section [31A-3-103](#);

3658 (ii) complete continuing education requirements under Section [31A-23a-202](#) before
3659 submitting the license renewal application;

3660 (iii) submit a completed renewal application as required by Section [31A-23a-104](#);

3661 (iv) submit additional documentation required to complete the licensing process as
3662 related to a specific license type or line of authority; or

3663 (v) maintain an active license in a ~~resident~~ licensee's home state if the licensee is a
3664 nonresident licensee.

3665 (b) (i) A licensee whose license lapses due to the following may request an action
3666 described in Subsection (1)(b)(ii):

3667 (A) military service;

3668 (B) voluntary service for a period of time designated by the person for whom the
3669 licensee provides voluntary service; or

3670 (C) some other extenuating circumstances, such as long-term medical disability.

3671 (ii) A licensee described in Subsection (1)(b)(i) may request:

3672 (A) reinstatement of the license no later than one year after the day on which the
3673 license lapses; and

3674 (B) waiver of any of the following imposed for failure to comply with renewal
3675 procedures:

3676 (I) an examination requirement;

3677 (II) reinstatement fees set under Section [31A-3-103](#);

3678 (III) continuing education requirements; or

3679 (IV) other sanction imposed for failure to comply with renewal procedures.

3680 (2) If a license issued under this chapter is voluntarily surrendered, the license or line
3681 of authority may be reinstated:

3682 (a) during the license period in which the license is voluntarily surrendered; and

3683 (b) no later than one year after the day on which the license is voluntarily surrendered.

3684 ~~[(3) A voluntarily surrendered license that is reinstated during the license period set~~
3685 ~~forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the~~
3686 ~~license complies with any applicable continuing education requirements for the period during~~
3687 ~~which the license was voluntarily surrendered.]~~

3688 Section 24. Section **31A-23a-202** is amended to read:

3689 **31A-23a-202. Continuing education requirements.**

3690 (1) Pursuant to this section, the commissioner shall by rule prescribe the continuing
3691 education requirements for a producer and a consultant.

3692 (2) (a) The commissioner may not state a continuing education requirement in terms of
3693 formal education.

3694 (b) The commissioner may state a continuing education requirement in terms of hours
3695 of insurance-related instruction received.

3696 (c) Insurance-related formal education may be a substitute, in whole or in part, for the
3697 hours required under Subsection (2)(b).

3698 (3) (a) The commissioner shall impose continuing education requirements in
3699 accordance with a two-year licensing period in which the licensee meets the requirements of
3700 this Subsection (3).

3701 (b) (i) Except as provided in this section, the continuing education requirements shall
3702 require:

3703 (A) that a licensee complete 24 credit hours of continuing education for every two-year
3704 licensing period;

3705 (B) that 3 of the 24 credit hours described in Subsection (3)(b)(i)(A) be ethics courses;
3706 and

3707 (C) that the licensee complete at least half of the required hours through classroom
3708 hours of insurance-related instruction.

3709 (ii) An hour of continuing education in accordance with Subsection (3)(b)(i) may be
3710 obtained through:

3711 (A) classroom attendance;

3712 (B) home study;

3713 (C) watching a video recording;

3714 (D) experience credit; or

3715 (E) another method provided by rule.

3716 (iii) (A) Notwithstanding Subsections (3)(b)(i)(A) and (B), an individual title insurance
3717 producer is required to complete 12 credit hours of continuing education for every two-year
3718 licensing period, with 3 of the credit hours being ethics courses unless the individual title
3719 insurance producer is licensed in this state as an individual title insurance producer for 20 or
3720 more consecutive years.

3721 (B) If an individual title insurance producer is licensed in this state as an individual
3722 title insurance producer for 20 or more consecutive years, the individual title insurance
3723 producer is required to complete 6 credit hours of continuing education for every two-year
3724 licensing period, with 3 of the credit hours being ethics courses.

3725 (C) Notwithstanding Subsection (3)(b)(iii)(A) or (B), an individual title insurance
3726 producer is considered to have met the continuing education requirements imposed under
3727 Subsection (3)(b)(iii)(A) or (B) if the individual title insurance producer:

3728 (I) is an active member in good standing with the Utah State Bar;

3729 (II) is in compliance with the continuing education requirements of the Utah State Bar;

3730 and

3731 (III) if requested by the department, provides the department evidence that the
3732 individual title insurance producer complied with the continuing education requirements of the
3733 Utah State Bar.

3734 (c) A licensee may obtain continuing education hours at any time during the two-year
3735 licensing period.

3736 (d) (i) A licensee is exempt from continuing education requirements under this section
3737 if:

3738 (A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;

3739 (B) the license does not have a continuous lapse for a period of more than one year,
3740 except for a license for which the licensee has had an exemption approved before May 11,
3741 2011;

3742 (C) the licensee requests an exemption from the department; and

3743 (D) the department approves the exemption.

3744 (ii) If the department approves the exemption under Subsection (3)(d)(i), the licensee is
3745 not required to apply again for the exemption.

3746 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3747 commissioner shall, by rule:

3748 (i) publish a list of insurance professional designations whose continuing education
3749 requirements can be used to meet the requirements for continuing education under Subsection
3750 (3)(b);

3751 (ii) authorize a continuing education provider or a state or national professional
3752 producer or consultant association to:

3753 (A) offer a qualified program for a license type or line of authority on a geographically
3754 accessible basis; and

3755 (B) collect a reasonable fee for funding and administration of a continuing education
3756 program, subject to the review and approval of the commissioner; and

3757 (iii) provide that membership by a producer or consultant in a state or national
3758 professional producer or consultant association is considered a substitute for the equivalent of
3759 two hours for each year during which the producer or consultant is a member of the
3760 professional association, except that the commissioner may not give more than two hours of
3761 continuing education credit in a year regardless of the number of professional associations of
3762 which the producer or consultant is a member.

3763 (f) A fee permitted under Subsection (3)(e)(ii)(B) that is charged for attendance at a
3764 professional producer or consultant association program may be less for an association
3765 member, on the basis of the member's affiliation expense, but shall preserve the right of a
3766 nonmember to attend without affiliation.

3767 (4) The commissioner shall approve a continuing education provider or continuing
3768 education course that satisfies the requirements of this section.

3769 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3770 commissioner shall by rule set the processes and procedures for continuing education provider
3771 registration and course approval.

3772 (6) The requirements of this section apply only to a producer or consultant who is an
3773 individual.

3774 (7) A nonresident producer or consultant is considered to have satisfied this state's
3775 continuing education requirements if the nonresident producer or consultant satisfies the
3776 nonresident producer's or consultant's home state's continuing education requirements for a

3777 licensed insurance producer or consultant.

3778 (8) A producer or consultant subject to this section shall keep documentation of
3779 completing the continuing education requirements of this section for two years after the end of
3780 the two-year licensing period to which the continuing education applies.

3781 Section 25. Section **31A-23a-203** is amended to read:

3782 **31A-23a-203. Training period requirements.**

3783 (1) A producer is eligible to become a surplus lines producer only if the producer:

3784 (a) has passed the applicable surplus lines producer examination;

3785 (b) has been a producer with property ~~[and]~~ or casualty or both lines of authority for at
3786 least three years during the four years immediately preceding the date of application; and

3787 (c) has paid the applicable fee under Section [31A-3-103](#).

3788 (2) A person is eligible to become a consultant only if the person has acted in a
3789 capacity that would provide the person with preparation to act as an insurance consultant for a
3790 period aggregating not less than three years during the four years immediately preceding the
3791 date of application.

3792 (3) (a) A resident producer with an accident and health line of authority may only sell
3793 long-term care insurance if the producer:

3794 (i) initially completes a minimum of three hours of long-term care training before
3795 selling long-term care coverage; and

3796 (ii) after completing the training required by Subsection (3)(a)(i), completes a
3797 minimum of three hours of long-term care training during each subsequent two-year licensing
3798 period.

3799 (b) A course taken to satisfy a long-term care training requirement may be used toward
3800 satisfying a producer continuing education requirement.

3801 (c) Long-term care training is not a continuing education requirement to renew a
3802 producer license.

3803 (d) An insurer that issues long-term care insurance shall demonstrate to the
3804 commissioner, upon request, that a producer who is appointed by the insurer and who sells
3805 long-term care insurance coverage is in compliance with this Subsection (3).

3806 (4) The training periods required under this section apply only to an individual
3807 applying for a license under this chapter.

3808 Section 26. Section **31A-23a-402.5** is amended to read:

3809 **31A-23a-402.5. Inducements.**

3810 (1) (a) Except as provided in Subsection (2), a producer, consultant, or other licensee
3811 under this title, or an officer or employee of a licensee, may not induce a person to enter into,
3812 continue, or terminate an insurance contract by offering a benefit that is not:

3813 (i) specified in the insurance contract; or

3814 (ii) directly related to the insurance contract.

3815 (b) An insurer may not make or knowingly allow an agreement of insurance that is not
3816 clearly expressed in the insurance contract to be issued or renewed.

3817 (c) A licensee under this title may not absorb the tax under Section [31A-3-301](#).

3818 (2) This section does not apply to a title insurer, an individual title insurance producer,
3819 or agency title insurance producer, or an officer or employee of a title insurer, an individual
3820 title insurance producer, or an agency title insurance producer.

3821 (3) Items not prohibited by Subsection (1) include an insurer:

3822 (a) reducing premiums because of expense savings;

3823 (b) providing to a policyholder or insured one or more incentives, as defined by the
3824 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
3825 Rulemaking Act, to participate in a program or activity designed to reduce claims or claim
3826 expenses, including:

3827 (i) a premium discount offered to a small or large employer group based on a wellness
3828 program if:

3829 (A) the premium discount for the employer group does not exceed 20% of the group
3830 premium; and

3831 (B) the premium discount based on the wellness program is offered uniformly by the
3832 insurer to all employer groups in the large or small group market;

3833 (ii) a premium discount offered to employees of a small or large employer group in an
3834 amount that does not exceed federal limits on wellness program incentives; or

3835 (iii) a combination of premium discounts offered to the employer group and the
3836 employees of an employer group, based on a wellness program, if:

3837 (A) the premium discounts for the employer group comply with Subsection (3)(b)(i);

3838 and

- 3839 (B) the premium discounts for the employees of an employer group comply with
3840 Subsection (3)(b)(ii); or
- 3841 (c) receiving premiums under an installment payment plan.
- 3842 (4) Items not prohibited by Subsection (1) include a producer, consultant, or other
3843 licensee, or an officer or employee of a licensee, either directly or through a third party:
- 3844 (a) engaging in a usual kind of social courtesy if receipt of the social courtesy is not
3845 conditioned on a quote or the purchase of a particular insurance product;
- 3846 (b) extending credit on a premium to the insured:
- 3847 (i) without interest, for no more than 90 days from the effective date of the insurance
3848 contract;
- 3849 (ii) for interest that is not less than the legal rate under Section 15-1-1, on the unpaid
3850 balance after the time period described in Subsection (4)(b)(i); and
- 3851 (iii) except that an installment or payroll deduction payment of premiums on an
3852 insurance contract issued under an insurer's mass marketing program is not considered an
3853 extension of credit for purposes of this Subsection (4)(b);
- 3854 (c) preparing or conducting a survey that:
- 3855 (i) is directly related to an accident and health insurance policy purchased from the
3856 licensee; or
- 3857 (ii) is used by the licensee to assess the benefit needs and preferences of insureds,
3858 employers, or employees directly related to an insurance product sold by the licensee;
- 3859 (d) providing limited human resource services that are directly related to an insurance
3860 product sold by the licensee, including:
- 3861 (i) answering questions directly related to:
- 3862 (A) an employee benefit offering or administration, if the insurance product purchased
3863 from the licensee is accident and health insurance or health insurance; and
- 3864 (B) employment practices liability, if the insurance product offered by or purchased
3865 from the licensee is property or casualty insurance; and
- 3866 (ii) providing limited human resource compliance training and education directly
3867 pertaining to an insurance product purchased from the licensee;
- 3868 (e) providing the following types of information or guidance:
- 3869 (i) providing guidance directly related to compliance with federal and state laws for an

- 3870 insurance product purchased from the licensee;
- 3871 (ii) providing a workshop or seminar addressing an insurance issue that is directly
3872 related to an insurance product purchased from the licensee; or
- 3873 (iii) providing information regarding:
- 3874 (A) employee benefit issues;
- 3875 (B) directly related insurance regulatory and legislative updates; or
- 3876 (C) similar education about an insurance product sold by the licensee and how the
3877 insurance product interacts with tax law;
- 3878 (f) preparing or providing a form that is directly related to an insurance product
3879 purchased from, or offered by, the licensee;
- 3880 (g) preparing or providing documents directly related to a premium only cafeteria plan
3881 within the meaning of Section 125, Internal Revenue Code, or a flexible spending account, but
3882 not providing ongoing administration of a flexible spending account;
- 3883 (h) providing enrollment and billing assistance, including:
- 3884 (i) providing benefit statements or new hire insurance benefits packages; and
- 3885 (ii) providing technology services such as an electronic enrollment platform or
3886 application system;
- 3887 (i) communicating coverages in writing and in consultation with the insured and
3888 employees;
- 3889 (j) providing employee communication materials and notifications directly related to an
3890 insurance product purchased from a licensee;
- 3891 (k) providing claims management and resolution to the extent permitted under the
3892 licensee's license;
- 3893 (l) providing underwriting or actuarial analysis or services;
- 3894 (m) negotiating with an insurer regarding the placement and pricing of an insurance
3895 product;
- 3896 (n) recommending placement and coverage options;
- 3897 (o) providing a health fair or providing assistance or advice on establishing or
3898 operating a wellness program, but not providing any payment for or direct operation of the
3899 wellness program;
- 3900 (p) providing COBRA and Utah mini-COBRA administration, consultations, and other

- 3901 services directly related to an insurance product purchased from the licensee;
- 3902 (q) assisting with a summary plan description, including providing a summary plan
3903 description wraparound;
- 3904 (r) providing information necessary for the preparation of documents directly related to
3905 the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq., as
3906 amended;
- 3907 (s) providing information or services directly related to the Health Insurance Portability
3908 and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended, such as services
3909 directly related to health care access, portability, and renewability when offered in connection
3910 with accident and health insurance sold by a licensee;
- 3911 (t) sending proof of coverage to a third party with a legitimate interest in coverage;
- 3912 (u) providing information in a form approved by the commissioner and directly related
3913 to determining whether an insurance product sold by the licensee meets the requirements of a
3914 third party contract that requires or references insurance coverage;
- 3915 (v) facilitating risk management services directly related to property and casualty
3916 insurance products sold or offered for sale by the licensee, including:
- 3917 (i) risk management;
- 3918 (ii) claims and loss control services;
- 3919 (iii) risk assessment consulting, including analysis of:
- 3920 (A) employer's job descriptions; or
- 3921 (B) employer's safety procedures or manuals; and
- 3922 (iv) providing information and training on best practices;
- 3923 (w) otherwise providing services that are legitimately part of servicing an insurance
3924 product purchased from a licensee; and
- 3925 (x) providing other directly related services approved by the department.
- 3926 (5) An inducement prohibited under Subsection (1) includes a producer, consultant, or
3927 other licensee, or an officer or employee of a licensee:
- 3928 (a) (i) providing a [~~premium or commission~~] rebate;
- 3929 (ii) paying the salary of an employee of a person who purchases an insurance product
3930 from the licensee; or
- 3931 (iii) if the licensee is an insurer, or a third party administrator who contracts with an

3932 insurer, paying the salary for an onsite staff member to perform an act prohibited under
3933 Subsection (5)(b)(xii); or
3934 (b) engaging in one or more of the following unless a fee is paid in accordance with
3935 Subsection (8):
3936 (i) performing background checks of prospective employees;
3937 (ii) providing legal services by a person licensed to practice law;
3938 (iii) performing drug testing that is directly related to an insurance product purchased
3939 from the licensee;
3940 (iv) preparing employer or employee handbooks, except that a licensee may:
3941 (A) provide information for a medical benefit section of an employee handbook;
3942 (B) provide information for the section of an employee handbook directly related to an
3943 employment practices liability insurance product purchased from the licensee; or
3944 (C) prepare or print an employee benefit enrollment guide;
3945 (v) providing job descriptions, postings, and applications for a person;
3946 (vi) providing payroll services;
3947 (vii) providing performance reviews or performance review training;
3948 (viii) providing union advice;
3949 (ix) providing accounting services;
3950 (x) providing data analysis information technology programs, except as provided in
3951 Subsection (4)(h)(ii);
3952 (xi) providing administration of health reimbursement accounts or health savings
3953 accounts; or
3954 (xii) if the licensee is an insurer, or a third party administrator who contracts with an
3955 insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of
3956 the following prohibited benefits:
3957 (A) performing background checks of prospective employees;
3958 (B) providing legal services by a person licensed to practice law;
3959 (C) performing drug testing that is directly related to an insurance product purchased
3960 from the insurer;
3961 (D) preparing employer or employee handbooks;
3962 (E) providing job descriptions postings, and applications;

3963 (F) providing payroll services;

3964 (G) providing performance reviews or performance review training;

3965 (H) providing union advice;

3966 (I) providing accounting services;

3967 (J) providing discrimination testing; or

3968 (K) providing data analysis information technology programs.

3969 (6) A producer, consultant, or other licensee or an officer or employee of a licensee

3970 shall itemize and bill separately from any other insurance product or service offered or

3971 provided under Subsection (5)(b).

3972 (7) (a) A de minimis gift or meal not to exceed a fair market value of \$25 for each
3973 individual receiving the gift or meal is presumed to be a social courtesy not conditioned on a
3974 quote or purchase of a particular insurance product for purposes of Subsection (4)(a).

3975 (b) Notwithstanding Subsection (4)(a), a de minimis gift or meal not to exceed \$10
3976 may be conditioned on receipt of a quote of a particular insurance product [~~if the de minimis~~
3977 ~~gift or meal is provided by the insurer and not by a producer or consultant~~].

3978 (8) If as provided under Subsection (5)(b) a producer, consultant, or other licensee is
3979 paid a fee to provide an item listed in Subsection (5)(b), the licensee shall comply with
3980 Subsection [31A-23a-501\(2\)](#) in charging the fee, except that the fee paid for the item shall equal
3981 or exceed the fair market value of the item.

3982 (9) For purposes of this section, "fair market value" is determined on the basis of what
3983 an individual insured or policyholder would pay on the open market for that item.

3984 Section 27. Section [31A-23a-501](#) is amended to read:

3985 **[31A-23a-501. Licensee compensation.](#)**

3986 (1) As used in this section:

3987 (a) "Commission compensation" includes funds paid to or credited for the benefit of a
3988 licensee from:

3989 (i) commission amounts deducted from insurance premiums on insurance sold by or
3990 placed through the licensee; [~~or~~]

3991 (ii) commission amounts received from an insurer or another licensee as a result of the
3992 sale or placement of insurance[~~;~~]; or

3993 (iii) overrides, bonuses, contingent bonuses, or contingent commissions received from

3994 an insurer or another licensee as a result of the sale or placement of insurance.

3995 (b) (i) "Compensation from an insurer or third party administrator" means
3996 commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,
3997 gifts, prizes, or any other form of valuable consideration:

3998 (A) whether or not payable pursuant to a written agreement; and

3999 (B) received from:

4000 (I) an insurer; or

4001 (II) a third party to the transaction for the sale or placement of insurance.

4002 (ii) "Compensation from an insurer or third party administrator" does not mean
4003 compensation from a customer that is:

4004 (A) a fee or pass-through costs as provided in Subsection (1)(e); or

4005 (B) a fee or amount collected by or paid to the producer that does not exceed an
4006 amount established by the commissioner by administrative rule.

4007 (c) (i) "Customer" means:

4008 (A) the person signing the application or submission for insurance; or

4009 (B) the authorized representative of the insured actually negotiating the placement of
4010 insurance with the producer.

4011 (ii) "Customer" does not mean a person who is a participant or beneficiary of:

4012 (A) an employee benefit plan; or

4013 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or
4014 negotiated by the producer or affiliate.

4015 (d) (i) "Noncommission compensation" includes all funds paid to or credited for the
4016 benefit of a licensee other than commission compensation.

4017 (ii) "Noncommission compensation" does not include charges for pass-through costs
4018 incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

4019 (e) "Pass-through costs" include:

4020 (i) costs for copying documents to be submitted to the insurer; and

4021 (ii) bank costs for processing cash or credit card payments.

4022 (2) A licensee may receive from an insured or from a person purchasing an insurance
4023 policy, noncommission compensation if the noncommission compensation is stated on a
4024 separate, written disclosure.

- 4025 (a) The disclosure required by this Subsection (2) shall:
- 4026 (i) include the signature of the insured or prospective insured acknowledging the
- 4027 noncommission compensation;
- 4028 (ii) clearly specify the amount or extent of the noncommission compensation; and
- 4029 (iii) be provided to the insured or prospective insured before the performance of the
- 4030 service.
- 4031 (b) Noncommission compensation shall be:
- 4032 (i) limited to actual or reasonable expenses incurred for services; and
- 4033 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of
- 4034 business or for a specific service or services.
- 4035 (c) A copy of the signed disclosure required by this Subsection (2) shall be maintained
- 4036 by any licensee who collects or receives the noncommission compensation or any portion of
- 4037 the noncommission compensation.
- 4038 (d) All accounting records relating to noncommission compensation shall be
- 4039 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.
- 4040 (3) (a) A licensee may receive noncommission compensation when acting as a
- 4041 producer for the insured in connection with the actual sale or placement of insurance if:
- 4042 (i) the producer and the insured have agreed on the producer's noncommission
- 4043 compensation; and
- 4044 (ii) the producer has disclosed to the insured the existence and source of any other
- 4045 compensation that accrues to the producer as a result of the transaction.
- 4046 (b) The disclosure required by this Subsection (3) shall:
- 4047 (i) include the signature of the insured or prospective insured acknowledging the
- 4048 noncommission compensation;
- 4049 (ii) clearly specify the amount or extent of the noncommission compensation and the
- 4050 existence and source of any other compensation; and
- 4051 (iii) be provided to the insured or prospective insured before the performance of the
- 4052 service.
- 4053 (c) The following additional noncommission compensation is authorized:
- 4054 (i) compensation received by a producer of a compensated corporate surety who under
- 4055 procedures approved by a rule or order of the commissioner is paid by surety bond principal

4056 debtors for extra services;

4057 (ii) compensation received by an insurance producer who is also licensed as a public
4058 adjuster under Section 31A-26-203, for services performed for an insured in connection with a
4059 claim adjustment, so long as the producer does not receive or is not promised compensation for
4060 aiding in the claim adjustment prior to the occurrence of the claim;

4061 (iii) compensation received by a consultant as a consulting fee, provided the consultant
4062 complies with the requirements of Section 31A-23a-401; or

4063 (iv) other compensation arrangements approved by the commissioner after a finding
4064 that they do not violate Section 31A-23a-401 and are not harmful to the public.

4065 (d) Subject to Section 31A-23a-402.5, a producer for the insured may receive
4066 compensation from an insured through an insurer, for the negotiation and sale of a health
4067 benefit plan, if there is a separate written agreement between the insured and the licensee for
4068 the compensation. An insurer who passes through the compensation from the insured to the
4069 licensee under this Subsection (3)(d) is not providing direct or indirect compensation or
4070 commission compensation to the licensee.

4071 (4) (a) For purposes of this Subsection (4), "producer" includes:

4072 (i) a producer;

4073 (ii) an affiliate of a producer; or

4074 (iii) a consultant.

4075 (b) A producer may not accept or receive any compensation from an insurer or third
4076 party administrator for the initial placement of a health benefit plan, other than a hospital
4077 confinement indemnity policy, unless prior to the customer's initial purchase of the health
4078 benefit plan the producer discloses in writing to the customer that the producer will receive
4079 compensation from the insurer or third party administrator for the placement of insurance,
4080 including the amount or type of compensation known to the producer at the time of the
4081 disclosure.

4082 (c) A producer shall:

4083 (i) obtain the customer's signed acknowledgment that the disclosure under Subsection
4084 (4)(b) was made to the customer; or

4085 (ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to
4086 the customer; and

4087 (B) keep the signed statement on file in the producer's office while the health benefit
4088 plan placed with the customer is in force.

4089 (d) (i) A licensee who collects or receives any part of the compensation from an insurer
4090 or third party administrator in a manner that facilitates an audit shall, while the health benefit
4091 plan placed with the customer is in force, maintain a copy of:

4092 (A) the signed acknowledgment described in Subsection (4)(c)(i); or

4093 (B) the signed statement described in Subsection (4)(c)(ii).

4094 (ii) The standard application developed in accordance with Section 31A-22-635 shall
4095 include a place for a producer to provide the disclosure required by this Subsection (4), and if
4096 completed, shall satisfy the requirement of Subsection (4)(d)(i).

4097 (e) Subsection (4)(c) does not apply to:

4098 (i) a person licensed as a producer who acts only as an intermediary between an insurer
4099 and the customer's producer, including a managing general agent; or

4100 (ii) the placement of insurance in a secondary or residual market.

4101 (5) This section does not alter the right of any licensee to recover from an insured the
4102 amount of any premium due for insurance effected by or through that licensee or to charge a
4103 reasonable rate of interest upon past-due accounts.

4104 (6) This section does not apply to bail bond producers or bail enforcement agents as
4105 defined in Section 31A-35-102.

4106 (7) A licensee may not receive noncommission compensation from an insured or
4107 enrollee for providing a service or engaging in an act that is required to be provided or
4108 performed in order to receive commission compensation, except for the surplus lines
4109 transactions that do not receive commissions.

4110 Section 28. Section 31A-23b-102 is amended to read:

4111 **31A-23b-102. Definitions.**

4112 As used in this chapter:

4113 (1) "Compensation" is as defined in:

4114 (a) Subsections 31A-23a-501(1)(a), (b), and (d); and

4115 (b) PPACA.

4116 (2) "Enroll" and "enrollment" mean to:

4117 (a) (i) obtain personally identifiable information about an individual; and

- 4118 (ii) inform an individual about accident and health insurance plans or public programs
4119 offered on an exchange;
- 4120 (b) solicit insurance; or
- 4121 (c) submit to the exchange:
- 4122 (i) personally identifiable information about an individual; and
- 4123 (ii) an individual's selection of a particular accident and health insurance plan or public
4124 program offered on the exchange.
- 4125 (3) (a) "Exchange" means an online marketplace~~[-(i) for an individual to purchase a~~
4126 ~~qualified health plan; and (ii)]~~ that is certified by the United States Department of Health and
4127 Human Services as either a state-based small employer exchange or a federally facilitated
4128 individual exchange under PPACA.
- 4129 (b) ~~[(+)]~~ "Exchange" does not include~~[-(A)]~~ an online marketplace for the purchase of
4130 health insurance if the online marketplace is not a certified exchange ~~[under PPACA; or]~~ in
4131 accordance with Subsection (3)(a).
- 4132 ~~[(B) except as provided in Subsection (3)(b)(ii), an online marketplace for small~~
4133 ~~employers that is certified as a PPACA compliant SHOP exchange.]~~
- 4134 ~~[(ii) For purposes of this chapter, exchange does include a small employer SHOP~~
4135 ~~exchange described under Subsection (3)(b)(i)(B) if:]~~
- 4136 ~~[(A) federal regulations under PPACA require a small employer exchange to allow~~
4137 ~~navigators to assist small employers and their employees with selection of qualified health~~
4138 ~~plans on a small employer exchange; and]~~
- 4139 ~~[(B) the state has not entered into an agreement with the United States Department of~~
4140 ~~Health and Human Services that permits the state to limit the scope of practice of navigators to~~
4141 ~~only the individual PPACA exchange.]~~
- 4142 (4) "Navigator":
- 4143 (a) means a person who facilitates enrollment in an exchange by offering to assist, or
4144 who advertises any services to assist, with:
- 4145 (i) the selection of and enrollment in a qualified health plan or a public program
4146 offered on an exchange; or
- 4147 (ii) applying for premium subsidies through an exchange; and
- 4148 (b) includes a person who is an in-person assister or ~~[an]~~ a certified application

4149 [~~assister~~] counselor as described in [~~(i)~~] federal regulations or guidance issued under PPACA[;
4150 ~~and~~].

4151 [~~(ii) the state exchange blueprint published by the Center for Consumer Information
4152 and Insurance Oversight within the Centers for Medicare and Medicaid Services in the United
4153 States Department of Health and Human Services.~~]

4154 (5) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

4155 (6) "Public programs" means the state Medicaid program in Title 26, Chapter 18,
4156 Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

4157 (7) "Resident" is as defined by rule made by the commissioner in accordance with Title
4158 63G, Chapter 3, Utah Administrative Rulemaking Act.

4159 [~~(7)~~] (8) "Solicit" is as defined in Section 31A-23a-102.

4160 Section 29. Section **31A-23b-202** is amended to read:

4161 **31A-23b-202. Qualifications for a license.**

4162 (1) (a) The commissioner shall issue or renew a license to a person to act as a navigator
4163 if the person:

4164 (i) satisfies the:

4165 (A) application requirements under Section 31A-23b-203;

4166 (B) character requirements under Section 31A-23b-204;

4167 (C) examination and training requirements under Section 31A-23b-205; and

4168 (D) continuing education requirements under Section 31A-23b-206;

4169 (ii) certifies that, to the extent applicable, the applicant:

4170 (A) is in compliance with the surety bond requirements of Section 31A-23b-207; and

4171 (B) will maintain compliance with Section 31A-23b-207 during the period for which
4172 the license is issued or renewed; and

4173 (iii) has not committed an act that is a ground for denial, suspension, or revocation as
4174 provided in Section 31A-23b-401.

4175 (b) A license issued under this chapter is valid for [~~two years~~] one year.

4176 (2) (a) A person shall report to the commissioner:

4177 (i) an administrative action taken against the person, including a denial of a new or
4178 renewal license application:

4179 (A) in another jurisdiction; or

- 4180 (B) by another regulatory agency in this state; and
- 4181 (ii) a criminal prosecution taken against the person in any jurisdiction.
- 4182 (b) The report required by Subsection (2)(a) shall be filed:
- 4183 (i) at the time the person files the application for an individual or agency license; and
- 4184 (ii) for an action or prosecution that occurs on or after the day on which the person files
- 4185 the application:
- 4186 (A) for an administrative action, within 30 days of the final disposition of the
- 4187 administrative action; or
- 4188 (B) for a criminal prosecution, within 30 days of the initial appearance before a court.
- 4189 (c) The report required by Subsection (2)(a) shall include a copy of the complaint or
- 4190 other relevant legal documents related to the action or prosecution described in Subsection
- 4191 (2)(a).
- 4192 (3) (a) The department may:
- 4193 (i) require a person applying for a license to submit to a criminal background check as
- 4194 a condition of receiving a license; or
- 4195 (ii) accept a background check conducted by another organization.
- 4196 (b) A person, if required to submit to a criminal background check under Subsection
- 4197 (3)(a), shall:
- 4198 (i) submit a fingerprint card in a form acceptable to the department; and
- 4199 (ii) consent to a fingerprint background check by:
- 4200 (A) the Utah Bureau of Criminal Identification; and
- 4201 (B) the Federal Bureau of Investigation.
- 4202 (c) For a person who submits a fingerprint card and consents to a fingerprint
- 4203 background check under Subsection (3)(b), the department may request:
- 4204 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part
- 4205 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
- 4206 (ii) complete Federal Bureau of Investigation criminal background checks through the
- 4207 national criminal history system.
- 4208 (d) Information obtained by the department from the review of criminal history records
- 4209 received under this Subsection (3) shall be used by the department for the purposes of:
- 4210 (i) determining if a person satisfies the character requirements under Section

- 4211 31A-23b-204 for issuance or renewal of a license;
- 4212 (ii) determining if a person failed to maintain the character requirements under Section
- 4213 31A-23b-204; and
- 4214 (iii) preventing a person who violates the federal Violent Crime Control and Law
- 4215 Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of a navigator or
- 4216 in-person assistor in the state.
- 4217 (e) If the department requests the criminal background information, the department
- 4218 shall:
- 4219 (i) pay to the Department of Public Safety the costs incurred by the Department of
- 4220 Public Safety in providing the department criminal background information under Subsection
- 4221 (3)(c)(i);
- 4222 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
- 4223 of Investigation in providing the department criminal background information under
- 4224 Subsection (3)(c)(ii); and
- 4225 (iii) charge the person applying for a license a fee equal to the aggregate of Subsections
- 4226 (3)(e)(i) and (ii).
- 4227 (4) The commissioner may deny an application for a license under this chapter if the
- 4228 person applying for the license:
- 4229 (a) fails to satisfy the requirements of this section; or
- 4230 (b) commits an act that is grounds for denial, suspension, or revocation as set forth in
- 4231 Section 31A-23b-401.
- 4232 Section 30. Section 31A-23b-205 is amended to read:
- 4233 **31A-23b-205. Examination and training requirements.**
- 4234 (1) The commissioner may require [~~applicants~~] an applicant for a license to pass an
- 4235 examination and complete a training program as a requirement for a license.
- 4236 (2) The examination described in Subsection (1) shall reasonably relate to:
- 4237 (a) the duties and functions of a navigator;
- 4238 (b) requirements for navigators as established by federal regulation under PPACA; and
- 4239 (c) other requirements that may be established by the commissioner by administrative
- 4240 rule.
- 4241 (3) The examination may be administered by the commissioner or as otherwise

4242 specified by administrative rule.

4243 (4) The training required by Subsection (1) shall be approved by the commissioner and
4244 shall include:

4245 (a) accident and health insurance plans;

4246 (b) qualifications for and enrollment in public programs;

4247 (c) qualifications for and enrollment in premium subsidies;

4248 (d) cultural and linguistic competence;

4249 (e) conflict of interest standards;

4250 (f) exchange functions; and

4251 (g) other requirements that may be adopted by the commissioner by administrative
4252 rule.

4253 (5) The training required by Subsection (1) shall consist of:

4254 (a) at least 21 credit hours of training before obtaining a license;

4255 (b) at least 1 of the 21 credit hours of training described in Subsection (5)(a) on defined
4256 contribution arrangement and the small employer Health Insurance Exchange created in
4257 accordance with Title 63M, Chapter 1, Part 25, Health System Reform Act; and

4258 (c) the navigator training and certification program developed by the Centers for
4259 Medicare and Medicaid Services.

4260 [~~5~~] (6) This section applies only to [~~applicants who are natural persons~~] an applicant
4261 who is a natural person.

4262 Section 31. Section **31A-23b-206** is amended to read:

4263 **31A-23b-206. Continuing education requirements.**

4264 (1) The commissioner shall, by rule, prescribe continuing education requirements for a
4265 navigator.

4266 (2) (a) The commissioner may not require a degree from an institution of higher
4267 education as part of continuing education.

4268 (b) The commissioner may state a continuing education requirement in terms of hours
4269 of instruction received in:

4270 (i) accident and health insurance;

4271 (ii) qualification for and enrollment in public programs;

4272 (iii) qualification for and enrollment in premium subsidies;

- 4273 (iv) cultural competency;
- 4274 (v) conflict of interest standards; and
- 4275 (vi) other exchange functions.
- 4276 (3) (a) Continuing education requirements shall require:
- 4277 (i) that a licensee complete ~~[24]~~ 12 credit hours of continuing education for every
- 4278 ~~[two-year]~~ one-year licensing period;
- 4279 (ii) that ~~[3]~~ at least 2 of the ~~[24]~~ 12 credit hours described in Subsection (3)(a)(i) be
- 4280 ethics courses; ~~[and]~~
- 4281 ~~[(iii) that the licensee complete at least half of the required hours through classroom~~
- 4282 ~~hours of insurance and exchange related instruction.]~~
- 4283 (iii) that at least 1 of the 12 credit hours described in Subsection (3)(a)(i) be a defined
- 4284 contribution course that includes training on use of the Health Insurance Exchange; and
- 4285 (iv) that a licensee complete the annual navigator training and certification program
- 4286 developed by the Centers for Medicare and Medicaid Services.
- 4287 (b) An hour of continuing education in accordance with Subsection (3)(a)(i) may be
- 4288 obtained through:
- 4289 (i) classroom attendance;
- 4290 (ii) home study;
- 4291 (iii) watching a video recording; or
- 4292 ~~[(iv) experience credit; or]~~
- 4293 ~~[(v)]~~ (iv) another method approved by rule.
- 4294 (c) A licensee may obtain continuing education hours at any time during the ~~[two-year]~~
- 4295 one-year license period.
- 4296 (d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
- 4297 commissioner shall~~;~~ by rule~~[(i) publish a list of insurance professional designations whose~~
- 4298 ~~continuing education requirements can be used to meet the requirements for continuing~~
- 4299 ~~education under Subsection (3)(b); and (ii)]~~ authorize one or more continuing education
- 4300 providers, including a state or national professional producer or consultant associations, to:
- 4301 ~~[(A)]~~ (i) offer a qualified program on a geographically accessible basis; and
- 4302 ~~[(B)]~~ (ii) collect a reasonable fee for funding and administration of a continuing
- 4303 education program, subject to the review and approval of the commissioner.

4304 (4) The commissioner shall approve a continuing education provider or a continuing
4305 education course that satisfies the requirements of this section.

4306 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
4307 commissioner shall by rule establish the procedures for continuing education provider
4308 registration and course approval.

4309 (6) This section applies only to a navigator who is a natural person.

4310 (7) A navigator shall keep documentation of completing the continuing education
4311 requirements of this section for two years after the end of the [~~two-year~~] one-year licensing
4312 period to which the continuing education applies.

4313 Section 32. Section **31A-23b-301** is amended to read:

4314 **31A-23b-301. Unfair practices -- Compensation -- Limit of scope of practice.**

4315 (1) As used in this section, "false or misleading information" includes, with intent to
4316 deceive a person examining it:

4317 (a) filing a report;

4318 (b) making a false entry in a record; or

4319 (c) willfully refraining from making a proper entry in a record.

4320 (2) (a) Communication that contains false or misleading information relating to
4321 enrollment in an insurance plan or a public program, including information that is false or
4322 misleading because it is incomplete, may not be made by:

4323 (i) a person who is or should be licensed under this title;

4324 (ii) an employee of a person described in Subsection (2)(a)(i);

4325 (iii) a person whose primary interest is as a competitor of a person licensed under this
4326 title; and

4327 (iv) a person on behalf of [~~any of the persons~~] a person listed in this Subsection (2)(a).

4328 (b) A licensee under this chapter may not:

4329 (i) use [~~any~~] a business name, slogan, emblem, or related device that is misleading or
4330 likely to cause the exchange, insurer, or other licensee to be mistaken for another governmental
4331 agency, a PPACA exchange, insurer, or other licensee already in business; or

4332 (ii) use [~~any~~] an advertisement or other insurance promotional material that would
4333 cause a reasonable person to mistakenly believe that a state or federal government agency,
4334 public program, or insurer:

4335 (A) is responsible for the insurance or public program enrollment assistance activities
4336 of the person;

4337 (B) stands behind the credit of the person; or

4338 (C) is a source of payment of ~~[any]~~ an insurance obligation of or sold by the person.

4339 (c) A person who is not an insurer may not assume or use ~~[any]~~ a name that deceptively
4340 implies or suggests that person is an insurer.

4341 (3) A person may not engage in an unfair method of competition or any other unfair or
4342 deceptive act or practice in the business of insurance, as defined by the commissioner by rule,
4343 after a finding that the method of competition, the act, or the practice:

4344 (a) is misleading;

4345 (b) is deceptive;

4346 (c) is unfairly discriminatory;

4347 (d) provides an unfair inducement; or

4348 (e) unreasonably restrains competition.

4349 (4) A navigator licensed under this chapter is subject to the unfair marketing practices
4350 and inducement provisions of ~~[Section]~~ Sections 31A-23a-402 and 31A-23a-402.5.

4351 (5) A navigator licensed under this chapter or who should be licensed under this
4352 chapter:

4353 (a) may not receive direct or indirect compensation from an accident or health insurer
4354 or from an individual who receives services from a navigator in accordance with:

4355 (i) federal conflict of interest regulations established pursuant to PPACA; and

4356 (ii) administrative rule adopted by the department;

4357 (b) may be compensated by the exchange for performing the duties of a navigator;

4358 (c) (i) may perform, offer to perform, or advertise a service as a navigator only for a
4359 person selecting a qualified health plan or public program offered on an exchange; and

4360 (ii) may not perform, offer to perform, or advertise ~~[any]~~ services as a navigator for
4361 individuals or small employer groups selecting accident and health insurance plans, qualified
4362 health plans, public programs, business, or services that are not offered on an exchange; and

4363 (d) may not recommend a particular accident and health insurance plan or qualified
4364 health plan.

4365 Section 33. Section **31A-23b-402** is amended to read:

4366 **31A-23b-402. Probation -- Grounds for revocation.**

4367 (1) The commissioner may place a licensee on probation for a period not to exceed 24
4368 months as follows:

4369 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
4370 Procedures Act, for any circumstances that would justify a suspension under this section; or

4371 (b) at the issuance of a new license:

4372 (i) with an admitted violation under 18 U.S.C. [~~Secs.~~] Sec. 1033 [~~and 1034~~]; or

4373 (ii) with a response to background information questions on a new license application
4374 indicating that:

4375 (A) the person has been convicted of a crime that is listed by rule made in accordance
4376 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is a ground for
4377 probation;

4378 (B) the person is currently charged with a crime that is listed by rule made in
4379 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
4380 a ground for probation regardless of whether adjudication is withheld;

4381 (C) the person has been involved in an administrative proceeding regarding any
4382 professional or occupational license; or

4383 (D) any business in which the person is or was an owner, partner, officer, or director
4384 has been involved in an administrative proceeding regarding any professional or occupational
4385 license.

4386 (2) The commissioner may place a licensee on probation for a specified period no
4387 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Secs.~~] Sec.
4388 1033 [~~and 1034~~].

4389 (3) The probation order shall state the conditions for revocation or retention of the
4390 license, which shall be reasonable.

4391 (4) Any violation of the probation is a ground for revocation pursuant to any
4392 proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

4393 Section 34. Section **31A-25-208** is amended to read:

4394 **31A-25-208. Revocation, suspension, surrender, lapsing, limiting, or otherwise**
4395 **terminating a license -- Rulemaking for renewal and reinstatement.**

4396 (1) A license type issued under this chapter remains in force until:

- 4397 (a) revoked or suspended under Subsection (4);
- 4398 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
4399 administrative action;
- 4400 (c) the licensee dies or is adjudicated incompetent as defined under:
- 4401 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
- 4402 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
4403 Minors;
- 4404 (d) lapsed under Section [31A-25-210](#); or
- 4405 (e) voluntarily surrendered.
- 4406 (2) The following may be reinstated within one year after the day on which the license
4407 is no longer in force:
- 4408 (a) a lapsed license; or
- 4409 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
4410 not be reinstated after the license period in which the license is voluntarily surrendered.
- 4411 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
4412 license, submission and acceptance of a voluntary surrender of a license does not prevent the
4413 department from pursuing additional disciplinary or other action authorized under:
- 4414 (a) this title; or
- 4415 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
4416 Administrative Rulemaking Act.
- 4417 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an
4418 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
4419 commissioner may:
- 4420 (i) revoke a license;
- 4421 (ii) suspend a license for a specified period of 12 months or less;
- 4422 (iii) limit a license in whole or in part; or
- 4423 (iv) deny a license application.
- 4424 (b) The commissioner may take an action described in Subsection (4)(a) if the
4425 commissioner finds that the licensee:
- 4426 (i) is unqualified for a license under Section [31A-25-202](#), [31A-25-203](#), or [31A-25-204](#);
- 4427 (ii) has violated:

- 4428 (A) an insurance statute;
- 4429 (B) a rule that is valid under Subsection 31A-2-201(3); or
- 4430 (C) an order that is valid under Subsection 31A-2-201(4);
- 4431 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
- 4432 delinquency proceedings in any state;
- 4433 (iv) fails to pay a final judgment rendered against the person in this state within 60
- 4434 days after the day on which the judgment became final;
- 4435 (v) fails to meet the same good faith obligations in claims settlement that is required of
- 4436 admitted insurers;
- 4437 (vi) is affiliated with and under the same general management or interlocking
- 4438 directorate or ownership as another third party administrator that transacts business in this state
- 4439 without a license;
- 4440 (vii) refuses:
- 4441 (A) to be examined; or
- 4442 (B) to produce its accounts, records, and files for examination;
- 4443 (viii) has an officer who refuses to:
- 4444 (A) give information with respect to the third party administrator's affairs; or
- 4445 (B) perform any other legal obligation as to an examination;
- 4446 (ix) provides information in the license application that is:
- 4447 (A) incorrect;
- 4448 (B) misleading;
- 4449 (C) incomplete; or
- 4450 (D) materially untrue;
- 4451 (x) has violated an insurance law, valid rule, or valid order of another state's insurance
- 4452 department;
- 4453 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 4454 (xii) has improperly withheld, misappropriated, or converted money or properties
- 4455 received in the course of doing insurance business;
- 4456 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 4457 (A) insurance contract; or
- 4458 (B) application for insurance;

- 4459 (xiv) has been convicted of a felony;
- 4460 (xv) has admitted or been found to have committed an insurance unfair trade practice
4461 or fraud;
- 4462 (xvi) in the conduct of business in this state or elsewhere has:
- 4463 (A) used fraudulent, coercive, or dishonest practices; or
- 4464 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 4465 (xvii) has had an insurance license or its equivalent, denied, suspended, or revoked in
4466 any other state, province, district, or territory;
- 4467 (xviii) has forged another's name to:
- 4468 (A) an application for insurance; or
- 4469 (B) a document related to an insurance transaction;
- 4470 (xix) has improperly used notes or any other reference material to complete an
4471 examination for an insurance license;
- 4472 (xx) has knowingly accepted insurance business from an individual who is not
4473 licensed;
- 4474 (xxi) has failed to comply with an administrative or court order imposing a child
4475 support obligation;
- 4476 (xxii) has failed to:
- 4477 (A) pay state income tax; or
- 4478 (B) comply with an administrative or court order directing payment of state income
4479 tax;
- 4480 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and
4481 Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 [~~and 1034~~] and therefore under 18 U.S.C.
4482 Sec. 1033 is prohibited from engaging in the business of insurance; or
- 4483 (xxiv) has engaged in methods and practices in the conduct of business that endanger
4484 the legitimate interests of customers and the public.
- 4485 (c) For purposes of this section, if a license is held by an agency, both the agency itself
4486 and any individual designated under the license are considered to be the holders of the agency
4487 license.
- 4488 (d) If an individual designated under the agency license commits an act or fails to
4489 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,

4490 the commissioner may suspend, revoke, or limit the license of:

4491 (i) the individual;

4492 (ii) the agency if the agency:

4493 (A) is reckless or negligent in its supervision of the individual; or

4494 (B) knowingly participated in the act or failure to act that is the ground for suspending,

4495 revoking, or limiting the license; or

4496 (iii) (A) the individual; and

4497 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

4498 (5) A licensee under this chapter is subject to the penalties for acting as a licensee

4499 without a license if:

4500 (a) the licensee's license is:

4501 (i) revoked;

4502 (ii) suspended;

4503 (iii) limited;

4504 (iv) surrendered in lieu of administrative action;

4505 (v) lapsed; or

4506 (vi) voluntarily surrendered; and

4507 (b) the licensee:

4508 (i) continues to act as a licensee; or

4509 (ii) violates the terms of the license limitation.

4510 (6) A licensee under this chapter shall immediately report to the commissioner:

4511 (a) a revocation, suspension, or limitation of the person's license in any other state, the

4512 District of Columbia, or a territory of the United States;

4513 (b) the imposition of a disciplinary sanction imposed on that person by any other state,

4514 the District of Columbia, or a territory of the United States; or

4515 (c) a judgment or injunction entered against the person on the basis of conduct

4516 involving:

4517 (i) fraud;

4518 (ii) deceit;

4519 (iii) misrepresentation; or

4520 (iv) a violation of an insurance law or rule.

4521 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a
4522 license in lieu of administrative action may specify a time, not to exceed five years, within
4523 which the former licensee may not apply for a new license.

4524 (b) If no time is specified in the order or agreement described in Subsection (7)(a), the
4525 former licensee may not apply for a new license for five years from the day on which the order
4526 or agreement is made without the express approval of the commissioner.

4527 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
4528 a license issued under this part if so ordered by the court.

4529 (9) The commissioner shall by rule prescribe the license renewal and reinstatement
4530 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4531 Section 35. Section **31A-25-209** is amended to read:

4532 **31A-25-209. Probation -- Grounds for revocation.**

4533 (1) The commissioner may place a licensee on probation for a period not to exceed 24
4534 months as follows:

4535 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
4536 Procedures Act, for any circumstances that would justify a suspension under Section
4537 [31A-25-208](#); or

4538 (b) at the issuance of a new license:

4539 (i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or

4540 (ii) with a response to a background information question on a new license application
4541 indicating that:

4542 (A) the person has been convicted of a crime that is listed by rule made in accordance
4543 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for
4544 probation;

4545 (B) the person is currently charged with a crime that is listed by rule made in
4546 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
4547 grounds for probation regardless of whether adjudication is withheld;

4548 (C) the person has been involved in an administrative proceeding regarding any
4549 professional or occupational license; or

4550 (D) any business in which the person is or was an owner, partner, officer, or director
4551 has been involved in an administrative proceeding regarding any professional or occupational

4552 license.

4553 (2) The commissioner may place a licensee on probation for a specified period no
4554 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [Sections]
4555 Sec. 1033 [and 1034].

4556 (3) A probation order under this section shall state the conditions for retention of the
4557 license, which shall be reasonable.

4558 (4) A violation of the probation is grounds for revocation pursuant to any proceeding
4559 authorized under Title 63G, Chapter 4, Administrative Procedures Act.

4560 Section 36. Section **31A-26-102** is amended to read:

4561 **31A-26-102. Definitions.**

4562 As used in this chapter, unless expressly provided otherwise:

4563 (1) "Company adjuster" means a person employed by an insurer whose regular duties
4564 include insurance adjusting.

4565 (2) "Designated home state" means the state or territory of the United States or the
4566 District of Columbia:

4567 (a) in which an insurance adjuster does not maintain the adjuster's principal:

4568 (i) place of residence; or

4569 (ii) place of business;

4570 (b) if the resident state, territory, or District of Columbia of the adjuster does not
4571 license adjusters for the line of authority sought, the adjuster has qualified for the license as if
4572 the person were a resident in the state, territory, or District of Columbia described in
4573 Subsection (2)(a), including an applicable:

4574 (i) examination requirement;

4575 (ii) fingerprint background check requirement; and

4576 (iii) continuing education requirement; and

4577 (c) the adjuster has designated the state, territory, or District of Columbia as the
4578 designated home state.

4579 (3) "Home state" means:

4580 (a) a state or territory of the United States or the District of Columbia in which an
4581 insurance adjuster:

4582 (i) maintains the adjuster's principal:

4583 (A) place of residence; or
 4584 (B) place of business; and
 4585 (ii) is licensed to act as a resident adjuster; or
 4586 (b) if the resident state, territory, or the District of Columbia described in Subsection
 4587 (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District
 4588 of Columbia:

4589 (i) in which the adjuster is licensed;
 4590 (ii) in which the adjuster is in good standing; and
 4591 (iii) that the adjuster has designated as the adjuster's designated home state.

4592 [~~(2)~~] (4) "Independent adjuster" means an insurance adjuster required to be licensed
 4593 under Section 31A-26-201, who engages in insurance adjusting as a representative of one or
 4594 more insurers.

4595 [~~(3)~~] (5) "Insurance adjusting" or "adjusting" means directing or conducting the
 4596 investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an
 4597 insurer, policyholder, or a claimant under an insurance policy.

4598 [~~(4)~~] (6) "Organization" means a person other than a natural person, and includes a sole
 4599 proprietorship by which a natural person does business under an assumed name.

4600 [~~(5)~~] (7) "Portable electronics insurance" is as defined in Section 31A-22-1802.

4601 [~~(6)~~] (8) "Public adjuster" means a person required to be licensed under Section
 4602 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants
 4603 under insurance policies.

4604 Section 37. Section 31A-26-206 is amended to read:

4605 **31A-26-206. Continuing education requirements.**

4606 (1) Pursuant to this section, the commissioner shall by rule prescribe continuing
 4607 education requirements for each class of license under Section 31A-26-204.

4608 (2) (a) The commissioner shall impose continuing education requirements in
 4609 accordance with a two-year licensing period in which the licensee meets the requirements of
 4610 this Subsection (2).

4611 (b) (i) Except as otherwise provided in this section, the continuing education
 4612 requirements shall require:

4613 (A) that a licensee complete 24 credit hours of continuing education for every two-year

4614 licensing period;

4615 (B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses;

4616 and

4617 (C) that the licensee complete at least half of the required hours through classroom

4618 hours of insurance-related instruction.

4619 (ii) A continuing education hour completed in accordance with Subsection (2)(b)(i)

4620 may be obtained through:

4621 (A) classroom attendance;

4622 (B) home study;

4623 (C) watching a video recording;

4624 (D) experience credit; or

4625 (E) other methods provided by rule.

4626 (iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is

4627 required to complete 12 credit hours of continuing education for every two-year licensing

4628 period, with 3 of the credit hours being ethics courses.

4629 (c) A licensee may obtain continuing education hours at any time during the two-year

4630 licensing period.

4631 (d) (i) A licensee is exempt from the continuing education requirements of this section

4632 if:

4633 (A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;

4634 (B) the license does not have a continuous lapse for a period of more than one year,

4635 except for a license for which the licensee has had an exemption approved before May 11,

4636 2011;

4637 (C) the licensee requests an exemption from the department; and

4638 (D) the department approves the exemption.

4639 (ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is

4640 not required to apply again for the exemption.

4641 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the

4642 commissioner shall by rule:

4643 (i) publish a list of insurance professional designations whose continuing education

4644 requirements can be used to meet the requirements for continuing education under Subsection

4645 (2)(b); and

4646 (ii) authorize a professional adjuster association to:

4647 (A) offer a qualified program for a classification of license on a geographically
4648 accessible basis; and

4649 (B) collect a reasonable fee for funding and administration of a qualified program,
4650 subject to the review and approval of the commissioner.

4651 (f) (i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and
4652 administer a qualified program shall reasonably relate to the cost of administering the qualified
4653 program.

4654 (ii) Nothing in this section shall prohibit a provider of a continuing education program
4655 or course from charging a fee for attendance at a course offered for continuing education credit.

4656 (iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an
4657 association program may be less for an association member, on the basis of the member's
4658 affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

4659 (3) The continuing education requirements of this section apply only to a licensee who
4660 is an individual.

4661 (4) The continuing education requirements of this section do not apply to a member of
4662 the Utah State Bar.

4663 (5) The commissioner shall designate a course that satisfies the requirements of this
4664 section, including a course presented by an insurer.

4665 (6) A nonresident adjuster is considered to have satisfied this state's continuing
4666 education requirements if:

4667 (a) the nonresident adjuster satisfies the nonresident producer's home state's continuing
4668 education requirements for a licensed insurance adjuster; and

4669 (b) on the same basis the nonresident adjuster's home state considers satisfaction of
4670 Utah's continuing education requirements for a producer as satisfying the continuing education
4671 requirements of the home state.

4672 (7) A licensee subject to this section shall keep documentation of completing the
4673 continuing education requirements of this section for two years after the end of the two-year
4674 licensing period to which the continuing education requirement applies.

4675 Section 38. Section **31A-26-207** is amended to read:

4676 **31A-26-207. Examination requirements.**

4677 (1) The commissioner may require applicants for ~~[any]~~ a particular class of license
4678 under Section 31A-26-204 to pass an examination as a requirement to receiving a license. The
4679 examination shall reasonably relate to the specific license class for which it is prescribed. The
4680 examinations may be administered by the commissioner or as specified by rule.

4681 (2) The commissioner shall waive the requirement of an examination for a nonresident
4682 applicant who:

4683 (a) applies for an insurance adjuster license in this state;

4684 (b) has been licensed for the same line of authority in another state; and

4685 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
4686 applies for an insurance producer license in this state; or

4687 (ii) if the application is received within 90 days of the cancellation of the applicant's
4688 previous license:

4689 (A) the prior state certifies that at the time of cancellation, the applicant was in good
4690 standing in that state; or

4691 (B) the state's producer database records maintained by the National Association of
4692 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
4693 subsidiaries, indicates that the producer is or was licensed in good standing for the line of
4694 authority requested.

4695 (3) (a) To become a resident licensee in accordance with Sections 31A-26-202 and
4696 31A-26-203, a person licensed as an insurance producer in another state who moves to this
4697 state shall make application within 90 days of establishing legal residence in this state.

4698 (b) A person who becomes a resident licensee under Subsection (3)(a) may not be
4699 required to meet prelicensing education or examination requirements to obtain any line of
4700 authority previously held in the prior state unless:

4701 (i) the prior state would require a prior resident of this state to meet the prior state's
4702 prelicensing education or examination requirements to become a resident licensee; or

4703 (ii) the commissioner imposes the requirements by rule.

4704 (4) The requirements of this section only apply to ~~[applicants who are natural persons]~~
4705 an applicant who is a natural person.

4706 (5) The requirements of this section do not apply to ~~[members]~~;

- 4707 (a) a member of the Utah State Bar[-]; or
4708 (b) an applicant for the crop insurance license class who has satisfactorily completed:
4709 (i) a national crop adjuster program, as adopted by the commissioner by rule; or
4710 (ii) the loss adjustment training curriculum and competency testing required by the
4711 Federal Crop Insurance Corporation Standard Reinsurance Agreement through the Risk
4712 Management Agency of the United States Department of Agriculture.

4713 Section 39. Section 31A-26-213 is amended to read:

4714 **31A-26-213. Revocation, suspension, surrender, lapsing, limiting, or otherwise**
4715 **terminating a license -- Rulemaking for renewal or reinstatement.**

4716 (1) A license type issued under this chapter remains in force until:

- 4717 (a) revoked or suspended under Subsection (5);
4718 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
4719 administrative action;

4720 (c) the licensee dies or is adjudicated incompetent as defined under:

- 4721 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
4722 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
4723 Minors;

4724 (d) lapsed under Section 31A-26-214.5; or

4725 (e) voluntarily surrendered.

4726 (2) The following may be reinstated within one year after the day on which the license
4727 is no longer in force:

- 4728 (a) a lapsed license; or
4729 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
4730 not be reinstated after the license period in which it is voluntarily surrendered.

4731 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
4732 license, submission and acceptance of a voluntary surrender of a license does not prevent the
4733 department from pursuing additional disciplinary or other action authorized under:

- 4734 (a) this title; or
4735 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
4736 Administrative Rulemaking Act.

4737 (4) A license classification issued under this chapter remains in force until:

4738 (a) the qualifications pertaining to a license classification are no longer met by the
4739 licensee; or

4740 (b) the supporting license type:

4741 (i) is revoked or suspended under Subsection (5); or

4742 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
4743 administrative action.

4744 (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an
4745 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
4746 commissioner may:

4747 (i) revoke:

4748 (A) a license; or

4749 (B) a license classification;

4750 (ii) suspend for a specified period of 12 months or less:

4751 (A) a license; or

4752 (B) a license classification;

4753 (iii) limit in whole or in part:

4754 (A) a license; or

4755 (B) a license classification; or

4756 (iv) deny a license application.

4757 (b) The commissioner may take an action described in Subsection (5)(a) if the
4758 commissioner finds that the licensee:

4759 (i) is unqualified for a license or license classification under Section [31A-26-202](#),
4760 [31A-26-203](#), [31A-26-204](#), or [31A-26-205](#);

4761 (ii) has violated:

4762 (A) an insurance statute;

4763 (B) a rule that is valid under Subsection [31A-2-201\(3\)](#); or

4764 (C) an order that is valid under Subsection [31A-2-201\(4\)](#);

4765 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
4766 delinquency proceedings in any state;

4767 (iv) fails to pay a final judgment rendered against the person in this state within 60
4768 days after the judgment became final;

- 4769 (v) fails to meet the same good faith obligations in claims settlement that is required of
4770 admitted insurers;
- 4771 (vi) is affiliated with and under the same general management or interlocking
4772 directorate or ownership as another insurance adjuster that transacts business in this state
4773 without a license;
- 4774 (vii) refuses:
- 4775 (A) to be examined; or
4776 (B) to produce its accounts, records, and files for examination;
- 4777 (viii) has an officer who refuses to:
- 4778 (A) give information with respect to the insurance adjuster's affairs; or
4779 (B) perform any other legal obligation as to an examination;
- 4780 (ix) provides information in the license application that is:
- 4781 (A) incorrect;
4782 (B) misleading;
4783 (C) incomplete; or
4784 (D) materially untrue;
- 4785 (x) has violated an insurance law, valid rule, or valid order of another state's insurance
4786 department;
- 4787 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
4788 (xii) has improperly withheld, misappropriated, or converted money or properties
4789 received in the course of doing insurance business;
- 4790 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 4791 (A) insurance contract; or
4792 (B) application for insurance;
- 4793 (xiv) has been convicted of a felony;
- 4794 (xv) has admitted or been found to have committed an insurance unfair trade practice
4795 or fraud;
- 4796 (xvi) in the conduct of business in this state or elsewhere has:
- 4797 (A) used fraudulent, coercive, or dishonest practices; or
4798 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 4799 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in

4800 any other state, province, district, or territory;

4801 (xviii) has forged another's name to:

4802 (A) an application for insurance; or

4803 (B) a document related to an insurance transaction;

4804 (xix) has improperly used notes or any other reference material to complete an

4805 examination for an insurance license;

4806 (xx) has knowingly accepted insurance business from an individual who is not

4807 licensed;

4808 (xxi) has failed to comply with an administrative or court order imposing a child

4809 support obligation;

4810 (xxii) has failed to:

4811 (A) pay state income tax; or

4812 (B) comply with an administrative or court order directing payment of state income

4813 tax;

4814 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and

4815 Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 [~~and 1034~~] and therefore under 18 U.S.C.

4816 Sec. 1033 is prohibited from engaging in the business of insurance; or

4817 (xxiv) has engaged in methods and practices in the conduct of business that endanger

4818 the legitimate interests of customers and the public.

4819 (c) For purposes of this section, if a license is held by an agency, both the agency itself

4820 and any individual designated under the license are considered to be the holders of the license.

4821 (d) If an individual designated under the agency license commits an act or fails to

4822 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,

4823 the commissioner may suspend, revoke, or limit the license of:

4824 (i) the individual;

4825 (ii) the agency, if the agency:

4826 (A) is reckless or negligent in its supervision of the individual; or

4827 (B) knowingly participated in the act or failure to act that is the ground for suspending,

4828 revoking, or limiting the license; or

4829 (iii) (A) the individual; and

4830 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

4831 (6) A licensee under this chapter is subject to the penalties for conducting an insurance
4832 business without a license if:

4833 (a) the licensee's license is:

4834 (i) revoked;

4835 (ii) suspended;

4836 (iii) limited;

4837 (iv) surrendered in lieu of administrative action;

4838 (v) lapsed; or

4839 (vi) voluntarily surrendered; and

4840 (b) the licensee:

4841 (i) continues to act as a licensee; or

4842 (ii) violates the terms of the license limitation.

4843 (7) A licensee under this chapter shall immediately report to the commissioner:

4844 (a) a revocation, suspension, or limitation of the person's license in any other state, the
4845 District of Columbia, or a territory of the United States;

4846 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
4847 the District of Columbia, or a territory of the United States; or

4848 (c) a judgment or injunction entered against that person on the basis of conduct
4849 involving:

4850 (i) fraud;

4851 (ii) deceit;

4852 (iii) misrepresentation; or

4853 (iv) a violation of an insurance law or rule.

4854 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
4855 license in lieu of administrative action may specify a time not to exceed five years within
4856 which the former licensee may not apply for a new license.

4857 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the
4858 former licensee may not apply for a new license for five years without the express approval of
4859 the commissioner.

4860 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
4861 a license issued under this part if so ordered by a court.

4862 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
4863 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4864 Section 40. Section **31A-26-214** is amended to read:

4865 **31A-26-214. Probation -- Grounds for revocation.**

4866 (1) The commissioner may place a licensee on probation for a period not to exceed 24
4867 months as follows:

4868 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
4869 Procedures Act, for any circumstances that would justify a suspension under Section

4870 [31A-26-213](#); or

4871 (b) at the issuance of a new license:

4872 (i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or

4873 (ii) with a response to a background information question on any new license

4874 application indicating that:

4875 (A) the person has been convicted of a crime, that is listed by rule made in accordance
4876 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for
4877 probation;

4878 (B) the person is currently charged with a crime, that is listed by rule made in
4879 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
4880 grounds for probation regardless of whether adjudication was withheld;

4881 (C) the person has been involved in an administrative proceeding regarding any
4882 professional or occupational license; or

4883 (D) any business in which the person is or was an owner, partner, officer, or director
4884 has been involved in an administrative proceeding regarding any professional or occupational
4885 license.

4886 (2) The commissioner may put a licensee on probation for a specified period no longer
4887 than 24 months if the licensee has admitted to violations under 18 U.S.C. [~~Sections~~] Sec. 1033
4888 [~~and 1034~~].

4889 (3) A probation order under this section shall state the conditions for retention of the
4890 license, which shall be reasonable.

4891 (4) A violation of the probation is grounds for revocation pursuant to any proceeding
4892 authorized under Title 63G, Chapter 4, Administrative Procedures Act.

- 4893 Section 41. Section **31A-26-214.5** is amended to read:
- 4894 **31A-26-214.5. License lapse and voluntary surrender.**
- 4895 (1) (a) A license issued under this chapter shall lapse if the licensee fails to:
- 4896 (i) pay when due a fee under Section **31A-3-103**;
- 4897 (ii) complete continuing education requirements under Section **31A-26-206** before
- 4898 submitting the license renewal application;
- 4899 (iii) submit a completed renewal application as required by Section **31A-26-202**;
- 4900 (iv) submit additional documentation required to complete the licensing process as
- 4901 related to a specific license type or license classification; or
- 4902 (v) maintain an active license in [~~a resident~~] the licensee's home state if the licensee is
- 4903 a nonresident licensee.
- 4904 (b) (i) A licensee whose license lapses due to the following may request an action
- 4905 described in Subsection (1)(b)(ii):
- 4906 (A) military service;
- 4907 (B) voluntary service for a period of time designated by the person for whom the
- 4908 licensee provides voluntary service; or
- 4909 (C) some other extenuating circumstances, such as long-term medical disability.
- 4910 (ii) A licensee described in Subsection (1)(b)(i) may request:
- 4911 (A) reinstatement of the license no later than one year after the day on which the
- 4912 license lapses; and
- 4913 (B) waiver of any of the following imposed for failure to comply with renewal
- 4914 procedures:
- 4915 (I) an examination requirement;
- 4916 (II) reinstatement fees set under Section **31A-3-103**;
- 4917 (III) continuing education requirements; or
- 4918 (IV) other sanction imposed for failure to comply with renewal procedures.
- 4919 (2) If a license issued under this chapter is voluntarily surrendered, the license may be
- 4920 reinstated:
- 4921 (a) during the license period in which it is voluntarily surrendered; and
- 4922 (b) no later than one year after the day on which the license is voluntarily surrendered.
- 4923 Section 42. Section **31A-27a-102** is amended to read:

4924 **31A-27a-102. Definitions.**

4925 As used in this chapter:

4926 (1) "Admitted assets" is as defined by and is measured in accordance with the National
4927 Association of Insurance Commissioner's Statements of Statutory Accounting Principles, as
4928 incorporated in this state by rules made by the department in accordance with Title 63G,
4929 Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection
4930 [31A-4-113\(1\)\(b\)\(ii\)](#).

4931 (2) "Affected guaranty association" means a guaranty association that is or may
4932 become liable for payment of a covered claim.

4933 (3) "Affiliate" is as defined in Section [31A-1-301](#).

4934 (4) Notwithstanding Section [31A-1-301](#), "alien insurer" means an insurer incorporated
4935 or organized under the laws of a jurisdiction that is not a state.

4936 (5) Notwithstanding Section [31A-1-301](#), "claimant" or "creditor" means a person
4937 having a claim against an insurer whether the claim is:

4938 (a) matured or not matured;

4939 (b) liquidated or unliquidated;

4940 (c) secured or unsecured;

4941 (d) absolute; or

4942 (e) fixed or contingent.

4943 (6) "Commissioner" is as defined in Section [31A-1-301](#).

4944 (7) "Commodity contract" means:

4945 (a) a contract for the purchase or sale of a commodity for future delivery on, or subject
4946 to the rules of:

4947 (i) a board of trade or contract market under the Commodity Exchange Act, 7 U.S.C.

4948 Sec. 1 et seq.; or

4949 (ii) a board of trade outside the United States;

4950 (b) an agreement that is:

4951 (i) subject to regulation under Section 19 of the Commodity Exchange Act, 7 U.S.C.

4952 Sec. 1 et seq.; and

4953 (ii) commonly known to the commodities trade as:

4954 (A) a margin account;

- 4955 (B) a margin contract;
- 4956 (C) a leverage account; or
- 4957 (D) a leverage contract;
- 4958 (c) an agreement or transaction that is:
- 4959 (i) subject to regulation under Section 4c(b) of the Commodity Exchange Act, 7 U.S.C.
- 4960 Sec. 1 et seq.; and
- 4961 (ii) commonly known to the commodities trade as a commodity option;
- 4962 (d) a combination of the agreements or transactions referred to in this Subsection (7);
- 4963 or
- 4964 (e) an option to enter into an agreement or transaction referred to in this Subsection (7).
- 4965 (8) "Control" is as defined in Section [31A-1-301](#).
- 4966 (9) "Delinquency proceeding" means a:
- 4967 (a) proceeding instituted against an insurer for the purpose of rehabilitating or
- 4968 liquidating the insurer; and
- 4969 (b) summary proceeding under Section [31A-27a-201](#).
- 4970 (10) "Department" is as defined in Section [31A-1-301](#) unless the context requires
- 4971 otherwise.
- 4972 (11) "Doing business," "doing insurance business," and "business of insurance"
- 4973 includes any of the following acts, whether effected by mail, electronic means, or otherwise:
- 4974 (a) issuing or delivering a contract, certificate, or binder relating to insurance or
- 4975 annuities:
- 4976 (i) to a person who is resident in this state; or
- 4977 (ii) covering a risk located in this state;
- 4978 (b) soliciting an application for the contract, certificate, or binder described in
- 4979 Subsection (11)(a);
- 4980 (c) negotiating preliminary to the execution of the contract, certificate, or binder
- 4981 described in Subsection (11)(a);
- 4982 (d) collecting premiums, membership fees, assessments, or other consideration for the
- 4983 contract, certificate, or binder described in Subsection (11)(a);
- 4984 (e) transacting matters:
- 4985 (i) subsequent to execution of the contract, certificate, or binder described in

4986 Subsection (11)(a); and

4987 (ii) arising out of the contract, certificate, or binder described in Subsection (11)(a);

4988 (f) operating as an insurer under a license or certificate of authority issued by the
4989 department; or

4990 (g) engaging in an act identified in Chapter 15, Unauthorized Insurers, Surplus Lines,
4991 and Risk Retention Groups.

4992 (12) Notwithstanding Section 31A-1-301, "domiciliary state" means the state in which
4993 an insurer is incorporated or organized, except that "domiciliary state" means:

4994 (a) in the case of an alien insurer, its state of entry; or

4995 (b) in the case of a risk retention group, the state in which the risk retention group is
4996 chartered as contemplated in the Liability Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.

4997 (13) "Estate" has the same meaning as "property of the insurer" as defined in
4998 Subsection (30).

4999 (14) "Fair consideration" is given for property or an obligation:

5000 (a) when in exchange for the property or obligation, as a fair equivalent for it, and in
5001 good faith:

5002 (i) property is conveyed;

5003 (ii) services are rendered;

5004 (iii) an obligation is incurred; or

5005 (iv) an antecedent debt is satisfied; or

5006 (b) when the property or obligation is received in good faith to secure a present

5007 advance or an antecedent debt in amount not disproportionately small compared to the value of
5008 the property or obligation obtained.

5009 (15) Notwithstanding Section 31A-1-301, "foreign insurer" means an insurer domiciled
5010 in another state.

5011 (16) "Formal delinquency proceeding" means a rehabilitation or liquidation
5012 proceeding.

5013 (17) "Forward contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C.
5014 Sec. 1821(e)(8)(D).

5015 (18) (a) "General assets" include all property of the estate that is not:

5016 (i) subject to a properly perfected secured claim;

5017 (ii) subject to a valid and existing express trust for the security or benefit of a specified
5018 person or class of person; or

5019 (iii) required by the insurance laws of this state or any other state to be held for the
5020 benefit of a specified person or class of person.

5021 (b) "General assets" [~~include all~~] includes the property of the estate or its proceeds in
5022 excess of the amount necessary to discharge a claim described in Subsection (18)(a).

5023 (19) "Good faith" means honesty in fact and intention, and in regard to Part 5, Asset
5024 Recovery, also requires the absence of:

5025 (a) information that would lead a reasonable person in the same position to know that
5026 the insurer is financially impaired or insolvent; and

5027 (b) knowledge regarding the imminence or pendency of a delinquency proceeding
5028 against the insurer.

5029 (20) "Guaranty association" means:

5030 (a) a mechanism mandated by Chapter 28, Guaranty Associations; or

5031 (b) a similar mechanism in another state that is created for the payment of claims or
5032 continuation of policy obligations of a financially impaired or insolvent insurer.

5033 (21) "Impaired" means that an insurer:

5034 (a) does not have admitted assets at least equal to the sum of:

5035 (i) all its liabilities; and

5036 (ii) the minimum surplus required to be maintained by Section 31A-5-211 or
5037 31A-8-209; or

5038 (b) has a total adjusted capital that is less than its authorized control level RBC, as
5039 defined in Section 31A-17-601.

5040 (22) "Insolvency" or "insolvent" means that an insurer:

5041 (a) is unable to pay its obligations when they are due;

5042 (b) does not have admitted assets at least equal to all of its liabilities; or

5043 (c) has a total adjusted capital that is less than its mandatory control level RBC, as
5044 defined in Section 31A-17-601.

5045 (23) Notwithstanding Section 31A-1-301, "insurer" means a person who:

5046 (a) is doing, has done, purports to do, or is licensed to do the business of insurance;

5047 (b) is or has been subject to the authority of, or to rehabilitation, liquidation,

5048 reorganization, supervision, or conservation by an insurance commissioner; or

5049 (c) is included under Section 31A-27a-104.

5050 (24) "Liabilities" is as defined by and is measured in accordance with the National
5051 Association of Insurance Commissioner's Statements of Statutory Accounting Principles, as
5052 incorporated in this state by rules made by the department in accordance with Title 63G,
5053 Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection
5054 31A-4-113(1)(b)(ii).

5055 (25) (a) Subject to Subsection (21)(b), "netting agreement" means:

5056 (i) a contract or agreement that:

5057 (A) documents one or more transactions between the parties to the agreement for or
5058 involving one or more qualified financial contracts; and

5059 (B) provides for the netting, liquidation, setoff, termination, acceleration, or close out
5060 under or in connection with:

5061 (I) one or more qualified financial contracts; or

5062 (II) present or future payment or delivery obligations or payment or delivery
5063 entitlements under the agreement, including liquidation or close-out values relating to the
5064 obligations or entitlements, among the parties to the netting agreement;

5065 (ii) a master agreement or bridge agreement for one or more master agreements
5066 described in Subsection (25)(a)(i); or

5067 (iii) any of the following related to a contract or agreement described in Subsection
5068 (25)(a)(i) or (ii):

5069 (A) a security agreement;

5070 (B) a security arrangement;

5071 (C) other credit enhancement or guarantee; or

5072 (D) a reimbursement obligation.

5073 (b) If a contract or agreement described in Subsection (25)(a)(i) or (ii) relates to an
5074 agreement or transaction that is not a qualified financial contract, the contract or agreement
5075 described in Subsection (25)(a)(i) or (ii) is considered a netting agreement only with respect to
5076 an agreement or transaction that is a qualified financial contract.

5077 (c) "Netting agreement" includes:

5078 (i) a term or condition incorporated by reference in the contract or agreement described

5079 in Subsection (25)(a); or

5080 (ii) a master agreement described in Subsection (25)(a).

5081 (d) A master agreement described in Subsection (25)(a), together with all schedules,
5082 confirmations, definitions, and addenda to that master agreement and transactions under any of
5083 the items described in this Subsection (25)(d), are treated as one netting agreement.

5084 (26) (a) "New value" means:

5085 (i) money;

5086 (ii) money's worth in goods, services, or new credit; or

5087 (iii) release by a transferee of property previously transferred to the transferee in a
5088 transaction that is neither void nor voidable by the insurer or the receiver under [any]
5089 applicable law, including proceeds of the property.

5090 (b) "New value" does not include an obligation substituted for an existing obligation.

5091 (27) "Party in interest" means:

5092 (a) the commissioner;

5093 (b) a nondomiciliary commissioner in whose state the insurer has outstanding claims
5094 liabilities;

5095 (c) an affected guaranty association; and

5096 (d) the following parties if the party files a request with the receivership court for
5097 inclusion as a party in interest and to be on the service list:

5098 (i) an insurer that ceded to or assumed business from the insurer;

5099 (ii) a policyholder;

5100 (iii) a third party claimant;

5101 (iv) a creditor;

5102 (v) a 10% or greater equity security holder in the insolvent insurer; and

5103 (vi) a person, including an indenture trustee, with a financial or regulatory interest in
5104 the delinquency proceeding.

5105 (28) (a) Notwithstanding Section [31A-1-301](#), "policy" means, notwithstanding what it
5106 is called:

5107 (i) a written contract of insurance;

5108 (ii) a written agreement for or affecting insurance; or

5109 (iii) a certificate of a written contract or agreement described in this Subsection (28)(a).

5110 (b) "Policy" includes all clauses, riders, endorsements, and papers that are a part of a
5111 policy.

5112 (c) "Policy" does not include a contract of reinsurance.

5113 (29) "Preference" means a transfer of property of an insurer to or for the benefit of a
5114 creditor:

5115 (a) for or on account of an antecedent debt, made or allowed by the insurer within one
5116 year before the day on which a successful petition for rehabilitation or liquidation is filed under
5117 this chapter;

5118 (b) the effect of which transfer may enable the creditor to obtain a greater percentage of
5119 the creditor's debt than another creditor of the same class would receive; and

5120 (c) if a liquidation order is entered while the insurer is already subject to a
5121 rehabilitation order and the transfer otherwise qualifies, that is made or allowed within the
5122 shorter of:

5123 (i) one year before the day on which a successful petition for rehabilitation is filed; or

5124 (ii) two years before the day on which a successful petition for liquidation is filed.

5125 (30) "Property of the insurer" or "property of the estate" includes:

5126 (a) a right, title, or interest of the insurer in property:

5127 (i) whether:

5128 (A) legal or equitable;

5129 (B) tangible or intangible; or

5130 (C) choate or inchoate; and

5131 (ii) including choses in action, contract rights, and any other interest recognized under
5132 the laws of this state;

5133 (b) entitlements that exist before the entry of an order of rehabilitation or liquidation;

5134 (c) entitlements that may arise by operation of this chapter or other provisions of law
5135 allowing the receiver to avoid prior transfers or assert other rights; and

5136 (d) (i) records or data that is otherwise the property of the insurer; and

5137 (ii) records or data similar to those described in Subsection (30)(d)(i) that are within
5138 the possession, custody, or control of a managing general agent, a third party administrator, a
5139 management company, a data processing company, an accountant, an attorney, an affiliate, or
5140 other person.

5141 (31) Subject to Subsection 31A-27a-611(10), "qualified financial contract" means any
5142 of the following:

5143 (a) a commodity contract;

5144 (b) a forward contract;

5145 (c) a repurchase agreement;

5146 (d) a securities contract;

5147 (e) a swap agreement; or

5148 (f) ~~any~~ a similar agreement that the commissioner determines by rule or order to be a
5149 qualified financial contract for purposes of this chapter.

5150 (32) As the context requires, "receiver" means the commissioner or the commissioner's
5151 designee, including a rehabilitator, liquidator, or ancillary receiver.

5152 (33) As the context requires, "receivership" means a rehabilitation, liquidation, or
5153 ancillary receivership.

5154 (34) Unless the context requires otherwise, "receivership court" refers to the court in
5155 which a delinquency proceeding is pending.

5156 (35) "Reciprocal state" means ~~any~~ a state other than this state that:

5157 (a) enforces a law substantially similar to this chapter;

5158 (b) requires the commissioner to be the receiver of a delinquent insurer; and

5159 (c) has laws for the avoidance of fraudulent conveyances and preferential transfers by
5160 the receiver of a delinquent insurer.

5161 (36) "Record," when used as a noun, means ~~any~~ information or data, in whatever
5162 form maintained, including:

5163 (a) a book;

5164 (b) a document;

5165 (c) a paper;

5166 (d) a file;

5167 (e) an application file;

5168 (f) a policyholder list;

5169 (g) policy information;

5170 (h) a claim or claim file;

5171 (i) an account;

- 5172 (j) a voucher;
- 5173 (k) a litigation file;
- 5174 (l) a premium record;
- 5175 (m) a rate book;
- 5176 (n) an underwriting manual;
- 5177 (o) a personnel record;
- 5178 (p) a financial record; or
- 5179 (q) other material.

5180 (37) "Reinsurance" means a transaction or contract under which an assuming insurer
5181 agrees to indemnify a ceding insurer against all, or a part, of ~~any~~ a loss that the ceding insurer
5182 may sustain under the one or more policies that the ceding insurer issues or will issue.

5183 (38) "Repurchase agreement" is as defined in the Federal Deposit Insurance Act, 12
5184 U.S.C. Sec. 1821(e)(8)(D).

5185 (39) (a) "Secured claim" means, subject to Subsection (39)(b):

- 5186 (i) a claim secured by an asset that is not a general asset; or
- 5187 (ii) the right to set off as provided in Section 31A-27a-510.

5188 (b) "Secured claim" does not include:

- 5189 (i) a special deposit claim;
- 5190 (ii) a claim based on mere possession; or
- 5191 (iii) a claim arising from a constructive or resulting trust.

5192 (40) "Securities contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C.
5193 Sec. 1821(e)(8)(D).

5194 (41) "Special deposit" means a deposit established pursuant to statute for the security
5195 or benefit of a limited class or classes of persons.

5196 (42) (a) Subject to Subsection (42)(b), "special deposit claim" means a claim secured
5197 by a special deposit.

5198 (b) "Special deposit claim" does not include a claim against the general assets of the
5199 insurer.

5200 (43) "State" means a state, district, or territory of the United States.

5201 (44) "Subsidiary" is as defined in Section 31A-1-301.

5202 (45) "Swap agreement" is as defined in the Federal Deposit Insurance Act, 12 U.S.C.

5203 Sec. 1821(e)(8)(D).

5204 (46) (a) "Transfer" includes the sale and every other and different mode of disposing of
5205 or parting with property or with an interest in property, whether:

5206 (i) directly or indirectly;

5207 (ii) absolutely or conditionally;

5208 (iii) voluntarily or involuntarily; or

5209 (iv) by or without judicial proceedings.

5210 (b) An interest in property includes:

5211 (i) a set off;

5212 (ii) having possession of the property; or

5213 (iii) fixing a lien on the property or on an interest in the property.

5214 (c) The retention of a security title in property delivered to an insurer and foreclosure
5215 of the insurer's equity of redemption is considered a transfer suffered by the insurer.

5216 (47) Notwithstanding Section 31A-1-301, "unauthorized insurer" means an insurer
5217 transacting the business of insurance in this state that has not received a certificate of authority
5218 from this state, or some other type of authority that allows for the transaction of the business of
5219 insurance in this state.

5220 Section 43. Section 31A-27a-107 is amended to read:

5221 **31A-27a-107. Notice and hearing on matters submitted by the receiver for**
5222 **receivership court approval.**

5223 (1) (a) Upon written request to the receiver, a person shall be placed on the service list
5224 to receive notice of matters filed by the receiver. The person shall include in a written request
5225 under this Subsection (1)(a) the person's address, facsimile number, or electronic mail address.

5226 (b) It is the responsibility of the person requesting notice to:

5227 (i) inform the receiver in writing of any changes in the person's address, facsimile
5228 number, or electronic mail address; or

5229 (ii) request that the person's name be deleted from the service list.

5230 (c) (i) The receiver may serve on a person on the service list a request to confirm
5231 continuation on the service list by returning a form.

5232 (ii) The request to confirm continuation may be served periodically but not more
5233 frequently than every 12 months.

5234 (iii) A person who fails to return the form described in this Subsection (1)(c) may be
5235 removed from the service list.

5236 (d) Inclusion on the service list does not confer standing in the delinquency proceeding
5237 to raise, appear, or be heard on any issue.

5238 (e) The receiver shall:

5239 (i) file a copy of the service list with the receivership court; and

5240 (ii) periodically provide to the receivership court notice of changes to the service list.

5241 (f) Notice may be provided by first-class mail postage paid, electronic mail, or
5242 facsimile transmission, at the receiver's discretion.

5243 (2) Except as otherwise provided by this chapter, notice and hearing of any matter
5244 submitted by the receiver to the receivership court for approval under this chapter shall be
5245 conducted in accordance with this Subsection (2).

5246 (a) The receiver:

5247 (i) shall file a motion:

5248 (A) explaining the proposed action; and

5249 (B) the basis for the proposed action; and

5250 (ii) may include any evidence in support of the motion.

5251 (b) If a document, material, or other information supporting the motion is confidential,
5252 the document, material, or other information may be submitted to the receivership court under
5253 seal for in camera inspection.

5254 (c) (i) The receiver shall provide notice and a copy of the motion to:

5255 (A) all persons on the service list; and

5256 (B) any other person as may be required by the receivership court.

5257 (ii) Notice may be provided by first-class mail postage paid, electronic mail, or
5258 facsimile transmission, at the receiver's discretion.

5259 (iii) For purposes of this section, notice is considered to be given on the day on which
5260 it is deposited with the United States Postmaster or transmitted, as applicable, to the
5261 last-known address as shown on the service list.

5262 (d) (i) A party in interest objecting to the motion shall:

5263 (A) file an objection specifying the grounds for the objection within:

5264 (I) 10 days of the day on which the notice of the filing of the motion is sent; or

- 5265 (II) such other time as the receivership court may specify; and
- 5266 (B) serve copies on:
- 5267 (I) the receiver; and
- 5268 (II) any other person served with the motion within the time period described in this
- 5269 Subsection (2)(d)(i).
- 5270 (ii) In accordance with the Utah Rules of Civil Procedure, days may be added to the
- 5271 time for filing an objection if the notice of the motion is sent only by way of United States
- 5272 mail.
- 5273 (iii) An objecting party has the burden of showing why the receivership court should
- 5274 not authorize the proposed action.
- 5275 (e) (i) If no objection to the motion is timely filed:
- 5276 (A) the receivership court may:
- 5277 (I) enter an order approving the motion without a hearing; or
- 5278 (II) hold a hearing to determine if the receiver's motion should be approved; and
- 5279 (B) the receiver may request that the receivership court enter an order or hold a hearing
- 5280 on an expedited basis.
- 5281 (ii) (A) If an objection is timely filed, the receivership court may hold a hearing.
- 5282 (B) If the receivership court approves the motion and, upon a motion by the receiver,
- 5283 determines that the objection is frivolous or filed merely for delay or for other improper
- 5284 purpose, the receivership court may order the objecting party to pay the receiver's reasonable
- 5285 costs and fees of defending against the objection.
- 5286 Section 44. Section **31A-27a-201** is amended to read:
- 5287 **31A-27a-201. Receivership court's seizure order.**
- 5288 (1) The commissioner may file in the Third District Court for Salt Lake County a
- 5289 petition:
- 5290 (a) with respect to:
- 5291 (i) an insurer domiciled in this state;
- 5292 (ii) an unauthorized insurer; or
- 5293 (iii) pursuant to Section **31A-27a-901**, a foreign insurer;
- 5294 (b) alleging that:
- 5295 (i) there exists grounds that would justify a court order for a formal delinquency

5296 proceeding against the insurer under this chapter; and

5297 (ii) the interests of policyholders, creditors, or the public will be endangered by delay;

5298 and

5299 (c) setting forth the contents of a seizure order considered necessary by the

5300 commissioner.

5301 (2) (a) Upon a filing under Subsection (1), the receivership court may issue the

5302 requested seizure order:

5303 (i) immediately, ex parte, and without notice or hearing;

5304 (ii) that directs the commissioner to take possession and control of:

5305 (A) all or a part of the property, accounts, and records of an insurer; and

5306 (B) the premises occupied by the insurer for transaction of the insurer's business; and

5307 (iii) that until further order of the receivership court, enjoins the insurer and its officers,

5308 managers, agents, and employees from disposition of its property and from the transaction of

5309 its business except with the written consent of the commissioner.

5310 (b) ~~Any~~ A person having possession or control of and refusing to deliver any of the

5311 records or assets of a person against whom a seizure order is issued under this Subsection (2) is

5312 guilty of a class B misdemeanor.

5313 (3) (a) A petition that requests injunctive relief:

5314 (i) shall be verified by the commissioner or the commissioner's designee; and

5315 (ii) is not required to plead or prove irreparable harm or inadequate remedy at law.

5316 (b) The commissioner shall provide only the notice that the receivership court may

5317 require.

5318 (4) (a) The receivership court shall specify in the seizure order the duration of the

5319 seizure, which shall be the time the receivership court considers necessary for the

5320 commissioner to ascertain the condition of the insurer.

5321 (b) The receivership court may from time to time:

5322 (i) hold a hearing that the receivership court considers desirable:

5323 (A) (I) on motion of the commissioner;

5324 (II) on motion of the insurer; or

5325 (III) on its own motion; and

5326 (B) after the notice the receivership court considers appropriate; and

5327 (ii) extend, shorten, or modify the terms of the seizure order.

5328 (c) The receivership court shall vacate the seizure order if the commissioner fails to
5329 commence a formal proceeding under this chapter after having had a reasonable opportunity to
5330 commence a formal proceeding under this chapter.

5331 (d) An order of the receivership court pursuant to a formal proceeding under this
5332 chapter vacates the seizure order.

5333 (5) Entry of a seizure order under this section does not constitute a breach or an
5334 anticipatory breach of ~~any~~ a contract of the insurer.

5335 (6) (a) An insurer subject to an ex parte seizure order under this section may petition
5336 the receivership court at any time after the issuance of a seizure order for a hearing and review
5337 of the basis for the seizure order.

5338 (b) The receivership court shall hold the hearing and review requested under this
5339 Subsection (6) not more than 15 days after the day on which the request is received or as soon
5340 thereafter as the court may allow.

5341 (c) A hearing under this Subsection (6):

5342 (i) may be held privately in chambers; and

5343 (ii) shall be held privately in chambers if the insurer proceeded against requests that it
5344 be private.

5345 (7) (a) If, at any time after the issuance of a seizure order, it appears to the receivership
5346 court that a person whose interest is or will be substantially affected by the seizure order did
5347 not appear at the hearing and has not been served, the receivership court may order that notice
5348 be given to the person.

5349 (b) An order under this Subsection (7) that notice be given may not stay the effect of
5350 ~~any~~ a seizure order previously issued by the receivership court.

5351 (8) Whenever the commissioner makes a seizure as provided in Subsection (2), on the
5352 demand of the commissioner, it shall be the duty of the sheriff of a county of this state, and of
5353 the police department of a municipality in the state to furnish the commissioner with necessary
5354 deputies or officers to assist the commissioner in making and enforcing the seizure order.

5355 (9) The commissioner may appoint a receiver under this section. The insurer shall pay
5356 the costs and expenses of the receiver appointed.

5357 Section 45. Section **31A-27a-701** is amended to read:

5358 **31A-27a-701. Priority of distribution.**

5359 (1) (a) The priority of payment of distributions on unsecured claims shall be in
5360 accordance with the order in which each class of claim is set forth in this section except as
5361 provided in Section [31A-27a-702](#).

5362 (b) All claims in each class shall be paid in full or adequate funds retained for the
5363 claim's payment before a member of the next class receives payment.

5364 (c) All claims within a class shall be paid substantially the same percentage.

5365 (d) Except as provided in Subsections (2)(a)(i)(E), (2)(k), and (2)(m), subclasses may
5366 not be established within a class.

5367 (e) A claim by a shareholder, policyholder, or other creditor may not be permitted to
5368 circumvent the priority classes through the use of equitable remedies.

5369 (2) The order of distribution of claims shall be as follows:

5370 (a) a Class 1 claim, which:

5371 (i) is a cost or expense of administration expressly approved or ratified by the
5372 liquidator, including the following:

5373 (A) the actual and necessary costs of preserving or recovering the property of the
5374 insurer;

5375 (B) reasonable compensation for all services rendered on behalf of the administrative
5376 supervisor or receiver;

5377 (C) a necessary filing fee;

5378 (D) the fees and mileage payable to a witness;

5379 (E) an unsecured loan obtained by the receiver, which:

5380 (I) unless its terms otherwise provide, has priority over all other costs of
5381 administration; and

5382 (II) absent agreement to the contrary, shares pro rata with all other claims described in
5383 this Subsection (2)(a)(i)(E); and

5384 (F) an expense approved by the rehabilitator of the insurer, if any, incurred in the
5385 course of the rehabilitation that is unpaid at the time of the entry of the order of liquidation; and

5386 (ii) except as expressly approved by the receiver, excludes any expense arising from a
5387 duty to indemnify a director, officer, or employee of the insurer which expense, if allowed, is a
5388 Class 7 claim;

- 5389 (b) a Class 2 claim, which:
- 5390 (i) is a reasonable expense of a guaranty association, including overhead, salaries, or
- 5391 other general administrative expenses allocable to the receivership such as:
- 5392 (A) an administrative or claims handling expense;
- 5393 (B) an expense in connection with arrangements for ongoing coverage; and
- 5394 (C) in the case of a property and casualty guaranty association, a loss adjustment
- 5395 expense, including:
- 5396 (I) an adjusting or other expense; and
- 5397 (II) a defense or cost containment expense; and
- 5398 (ii) excludes an expense incurred in the performance of duties under Section
- 5399 31A-28-112 or similar duties under the statute governing a similar organization in another
- 5400 state;
- 5401 (c) a Class 3 claim, which:
- 5402 (i) is:
- 5403 (A) a claim under a policy of insurance including a third party claim;
- 5404 (B) a claim under an annuity contract or funding agreement;
- 5405 (C) a claim under a nonassessable policy for unearned premium;
- 5406 (D) a claim of an obligee and, subject to the discretion of the receiver, a completion
- 5407 contractor under a surety bond or surety undertaking, except for:
- 5408 (I) a bail bond;
- 5409 (II) a mortgage guaranty;
- 5410 (III) a financial guaranty; or
- 5411 (IV) other form of insurance offering protection against investment risk or warranties;
- 5412 (E) a claim by a principal under a surety bond or surety undertaking for wrongful
- 5413 dissipation of collateral by the insurer or its agents;
- 5414 (F) an indemnity payment on:
- 5415 (I) a covered claim; or
- 5416 [~~(H) unearned premium; or~~]
- 5417 [~~(H)~~] (II) a payment for the continuation of coverage made by an entity responsible for
- 5418 the payment of a claim or continuation of coverage of an insolvent health maintenance
- 5419 organization;

5420 (G) a claim for unearned premium;
5421 ~~[(G)]~~ (H) a claim incurred during the extension of coverage provided for in Sections
5422 31A-27a-402 and 31A-27a-403; or
5423 ~~[(H)]~~ (I) all other claims incurred in fulfilling the statutory obligations of a guaranty
5424 association not included in Class 2, including:
5425 (I) an indemnity payment on covered claims; and
5426 (II) in the case of a life and health guaranty association, a claim:
5427 (Aa) as a creditor of the impaired or insolvent insurer for a payment of and liabilities
5428 incurred on behalf of a covered claim or covered obligation of the insurer; and
5429 (Bb) for the funds needed to reinsure the obligations described under this Subsection
5430 (2)(c)(i)(H)(II) with a solvent insurer; and
5431 (ii) notwithstanding any other provision of this chapter, excludes the following which
5432 shall be paid under Class 7, except as provided in this section:
5433 (A) an obligation of the insolvent insurer arising out of a reinsurance contract;
5434 (B) an obligation that is incurred pursuant to an occurrence policy or reported pursuant
5435 to a claims made policy after:
5436 (I) the expiration date of the policy;
5437 (II) the policy is replaced by the insured;
5438 (III) the policy is canceled at the insured's request; or
5439 (IV) the policy is canceled as provided in this chapter;
5440 (C) an obligation to an insurer, insurance pool, or underwriting association and the
5441 insurer's, insurance pool's, or underwriting association's claim for contribution, indemnity, or
5442 subrogation, equitable or otherwise, except for direct claims under a policy where the insurer is
5443 the named insured;
5444 (D) an amount accrued as punitive or exemplary damages unless expressly covered
5445 under the terms of the policy, which shall be paid as a claim in Class 9;
5446 (E) a tort claim of any kind against the insurer;
5447 (F) a claim against the insurer for bad faith or wrongful settlement practices; and
5448 (G) a claim of a guaranty association for assessments not paid by the insurer, which
5449 claims shall be paid as claims in Class 7; and
5450 (iii) notwithstanding Subsection (2)(c)(ii)(B), does not exclude an unearned premium

- 5451 claim on a policy, other than a reinsurance agreement;
- 5452 (d) a Class 4 claim, which is a claim under a policy for mortgage guaranty, financial
- 5453 guaranty, or other forms of insurance offering protection against investment risk or warranties;
- 5454 (e) a Class 5 claim, which is a claim of the federal government not included in Class 3
- 5455 or 4;
- 5456 (f) a Class 6 claim, which is a debt due an employee for services or benefits:
- 5457 (i) to the extent that the expense:
- 5458 (A) does not exceed the lesser of:
- 5459 (I) \$5,000; or
- 5460 (II) two months' salary; and
- 5461 (B) represents payment for services performed within one year before the day on which
- 5462 the initial order of receivership is issued; and
- 5463 (ii) which priority is in lieu of any other similar priority that may be authorized by law
- 5464 as to wages or compensation of employees;
- 5465 (g) a Class 7 claim, which is a claim of an unsecured creditor not included in Classes 1
- 5466 through 6, including:
- 5467 (i) a claim under a reinsurance contract;
- 5468 (ii) a claim of a guaranty association for an assessment not paid by the insurer; and
- 5469 (iii) other claims excluded from Class 3 or 4, unless otherwise assigned to Classes 8
- 5470 through 13;
- 5471 (h) subject to Subsection (3), a Class 8 claim, which is:
- 5472 (i) a claim of a state or local government, except a claim specifically classified
- 5473 elsewhere in this section; or
- 5474 (ii) a claim for services rendered and expenses incurred in opposing a formal
- 5475 delinquency proceeding;
- 5476 (i) a Class 9 claim, which is a claim for penalties, punitive damages, or forfeitures,
- 5477 unless expressly covered under the terms of a policy of insurance;
- 5478 (j) a Class 10 claim, which is, except as provided in Subsections [31A-27a-601\(2\)](#) and
- 5479 [31A-27a-601\(3\)](#), a late filed claim that would otherwise be classified in Classes 3 through 9;
- 5480 (k) subject to Subsection (4), a Class 11 claim, which is:
- 5481 (i) a surplus note;

- 5482 (ii) a capital note;
- 5483 (iii) a contribution note;
- 5484 (iv) a similar obligation;
- 5485 (v) a premium refund on an assessable policy; or
- 5486 (vi) any other claim specifically assigned to this class;
- 5487 (l) a Class 12 claim, which is a claim for interest on an allowed claim of Classes 1
- 5488 through 11, according to the terms of a plan to pay interest on allowed claims proposed by the
- 5489 liquidator and approved by the receivership court; and
- 5490 (m) subject to Subsection (4), a Class 13 claim, which is a claim of a shareholder or
- 5491 other owner arising out of:
- 5492 (i) the shareholder's or owner's capacity as shareholder or owner or any other capacity;
- 5493 and
- 5494 (ii) except as the claim may be qualified in Class 3, 4, 7, or 12.
- 5495 (3) To prove a claim described in Class 8, the claimant shall show that:
- 5496 (a) the insurer that is the subject of the delinquency proceeding incurred the fee or
- 5497 expense on the basis of the insurer's best knowledge, information, and belief:
- 5498 (i) formed after reasonable inquiry indicating opposition is in the best interests of the
- 5499 insurer;
- 5500 (ii) that is well grounded in fact; and
- 5501 (iii) is warranted by existing law or a good faith argument for the extension,
- 5502 modification, or reversal of existing law; and
- 5503 (b) opposition is not pursued for any improper purpose, such as to harass, to cause
- 5504 unnecessary delay, or to cause needless increase in the cost of the litigation.
- 5505 (4) (a) A claim in Class 11 is subject to a subordination agreement related to other
- 5506 claims in Class 11 that exist before the entry of a liquidation order.
- 5507 (b) A claim in Class 13 is subject to a subordination agreement, related to other claims
- 5508 in Class 13 that exist before the entry of a liquidation order.
- 5509 Section 46. Section **31A-29-106** is amended to read:
- 5510 **31A-29-106. Powers of board.**
- 5511 (1) The board shall have the general powers and authority granted under the laws of
- 5512 this state to insurance companies licensed to transact health care insurance business. In

5513 addition, the board shall have the specific authority to:

5514 (a) enter into contracts to carry out the provisions and purposes of this chapter,

5515 including, with the approval of the commissioner, contracts with:

5516 (i) similar pools of other states for the joint performance of common administrative
5517 functions; or

5518 (ii) persons or other organizations for the performance of administrative functions;

5519 (b) sue or be sued, including taking such legal action necessary to avoid the payment of
5520 improper claims against the pool or the coverage provided through the pool;

5521 (c) establish appropriate rates, rate schedules, rate adjustments, expense allowances,
5522 agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the
5523 operation of the pool;

5524 (d) issue policies of insurance in accordance with the requirements of this chapter;

5525 (e) retain an executive director and appropriate legal, actuarial, and other personnel as
5526 necessary to provide technical assistance in the operations of the pool;

5527 (f) establish rules, conditions, and procedures for reinsuring risks under this chapter;

5528 (g) cause the pool to have an annual audit of its operations by the state auditor;

5529 (h) coordinate with the Department of Health in seeking to obtain from the Centers for
5530 Medicare and Medicaid Services, or other appropriate office or agency of government, all
5531 appropriate waivers, authority, and permission needed to coordinate the coverage available
5532 from the pool with coverage available under Medicaid, either before or after Medicaid
5533 coverage, or as a conversion option upon completion of Medicaid eligibility, without the
5534 necessity for requalification by the enrollee;

5535 (i) provide for and employ cost containment measures and requirements including
5536 preadmission certification, concurrent inpatient review, and individual case management for
5537 the purpose of making the pool more cost-effective;

5538 (j) offer pool coverage through contracts with health maintenance organizations,
5539 preferred provider organizations, and other managed care systems that will manage costs while
5540 maintaining quality care;

5541 (k) establish annual limits on benefits payable under the pool to or on behalf of any
5542 enrollee;

5543 (l) exclude from coverage under the pool specific benefits, medical conditions, and

5544 procedures for the purpose of protecting the financial viability of the pool;
5545 (m) administer the Pool Fund;
5546 (n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative
5547 Rulemaking Act, to implement this chapter;
5548 (o) adopt, trademark, and copyright a trade name for the pool for use in marketing and
5549 publicizing the pool and its products; and
5550 (p) transition health care coverage for all individuals covered under the pool as part of
5551 the conversion to health insurance coverage, regardless of preexisting conditions, under
5552 PPACA.

5553 (2) (a) The board shall prepare and submit an annual report to the Legislature which
5554 shall include:

- 5555 (i) the net premiums anticipated;
- 5556 (ii) actuarial projections of payments required of the pool;
- 5557 (iii) the expenses of administration; and
- 5558 (iv) the anticipated reserves or losses of the pool.

5559 (b) The budget for operation of the pool is subject to the approval of the board.

5560 (c) The administrative budget of the board and the commissioner under this chapter
5561 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is
5562 subject to review and approval by the Legislature.

5563 ~~[(3) (a) The board shall on or before September 1, 2004, require the plan administrator~~
5564 ~~or an independent actuarial consultant retained by the plan administrator to redetermine the~~
5565 ~~reasonable equivalent of the criteria for uninsurability required under Subsection~~
5566 ~~31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.]~~

5567 ~~[(b) The board shall redetermine the criteria established in Subsection (3)(a) at least~~
5568 ~~every five years thereafter.]~~

5569 Section 47. Section **31A-29-111** is amended to read:

5570 **31A-29-111. Eligibility -- Limitations.**

5571 (1) (a) Except as provided in Subsection (1)(b), an individual who is not HIPAA
5572 eligible is eligible for pool coverage if the individual:

- 5573 (i) pays the established premium;
- 5574 (ii) is a resident of this state; and

- 5575 (iii) meets the health underwriting criteria under Subsection (5)(a).
- 5576 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not
5577 eligible for pool coverage if one or more of the following conditions apply:
- 5578 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
5579 except as provided in Section [31A-29-112](#);
- 5580 (ii) the individual has terminated coverage in the pool, unless:
- 5581 (A) 12 months have elapsed since the termination date; or
- 5582 (B) the individual demonstrates that creditable coverage has been involuntarily
5583 terminated for any reason other than nonpayment of premium;
- 5584 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;
- 5585 (iv) the individual is an inmate of a public institution;
- 5586 (v) the individual is eligible for a public health plan, as defined in federal regulations
5587 adopted pursuant to 42 U.S.C. Sec. 300gg;
- 5588 (vi) the individual's health condition does not meet the criteria established under
5589 Subsection (5);
- 5590 (vii) the individual is eligible for coverage under an employer group that offers a health
5591 benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members
5592 as:
- 5593 (A) an eligible employee;
- 5594 (B) a dependent of an eligible employee; or
- 5595 (C) a member;
- 5596 (viii) the individual is covered under any other health benefit plan;
- 5597 (ix) except as provided in Subsections (3) and (6), at the time of application, the
5598 individual has not resided in Utah for at least 12 consecutive months preceding the date of
5599 application; or
- 5600 (x) the individual's employer pays any part of the individual's health benefit plan
5601 premium, either as an insured or a dependent, for pool coverage.
- 5602 (2) (a) Except as provided in Subsection (2)(b), an individual who is HIPAA eligible is
5603 eligible for pool coverage if the individual:
- 5604 (i) pays the established premium; and
- 5605 (ii) is a resident of this state.

5606 (b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for
5607 pool coverage if one or more of the following conditions apply:

5608 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
5609 except as provided in Section 31A-29-112;

5610 (ii) the individual is eligible for a public health plan, as defined in federal regulations
5611 adopted pursuant to 42 U.S.C. Sec. 300gg;

5612 (iii) the individual is covered under any other health benefit plan;

5613 (iv) the individual is eligible for coverage under an employer group that offers a health
5614 benefit plan or self-insurance arrangements to its eligible employees, dependents, or members
5615 as:

5616 (A) an eligible employee;

5617 (B) a dependent of an eligible employee; or

5618 (C) a member;

5619 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

5620 (vi) the individual is an inmate of a public institution; or

5621 (vii) the individual's employer pays any part of the individual's health benefit plan
5622 premium, either as an insured or a dependent, for pool coverage.

5623 (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
5624 (1)(a), an individual whose health care insurance coverage from a state high risk pool with
5625 similar coverage is terminated because of nonresidency in another state is eligible for coverage
5626 under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

5627 (b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the
5628 termination date of the previous high risk pool coverage.

5629 (c) The effective date of this state's pool coverage shall be the date of termination of
5630 the previous high risk pool coverage.

5631 (d) The waiting period of an individual with a preexisting condition applying for
5632 coverage under this chapter shall be waived:

5633 (i) to the extent to which the waiting period was satisfied under a similar plan from
5634 another state; and

5635 (ii) if the other state's benefit limitation was not reached.

5636 (4) (a) If an eligible individual applies for pool coverage within 30 days of being

5637 denied coverage by an individual carrier, the effective date for pool coverage shall be no later
5638 than the first day of the month following the date of submission of the completed insurance
5639 application to the carrier.

5640 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under
5641 Subsection (3), the effective date shall be the date of termination of the previous high risk pool
5642 coverage.

5643 (5) (a) The board shall establish and adjust, as necessary, health underwriting criteria
5644 based on:

5645 (i) health condition; and

5646 (ii) expected claims so that the expected claims are anticipated to remain within
5647 available funding.

5648 (b) The board, with approval of the commissioner, may contract with one or more
5649 providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting
5650 criteria under Subsection (5)(a).

5651 ~~[(c) If an individual is denied coverage by the pool under the criteria established in~~
5652 ~~Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage~~
5653 ~~under Subsection 31A-30-108(3).]~~

5654 (6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
5655 (1)(a), an individual whose individual health care insurance coverage was involuntarily
5656 terminated, is eligible for coverage under the pool subject to the conditions of Subsections
5657 (1)(b)(i) through (viii) and (x).

5658 (b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the
5659 termination date of the previous individual health care insurance coverage.

5660 (c) The effective date of this state's pool coverage shall be the date of termination of
5661 the previous individual coverage.

5662 (d) The waiting period of an individual with a preexisting condition applying for
5663 coverage under this chapter shall be waived to the extent to which the waiting period was
5664 satisfied under the individual health insurance plan.

5665 Section 48. Section **31A-29-115** is amended to read:

5666 **31A-29-115. Cancellation -- Notice.**

5667 (1) ~~[(a)]~~ On the date of renewal, the pool may cancel an enrollee's policy if:

5668 [(i)] (a) the enrollee's health condition does not meet the criteria established in
5669 Subsection 31A-29-111(5); and

5670 [(ii)] (b) the pool has provided written notice to the enrollee's last-known address no
5671 less than 60 days before cancellation[; and].

5672 [(iii)] ~~at least one individual carrier has not reached the individual enrollment cap~~
5673 ~~established in Section 31A-30-110.~~

5674 [(b)] ~~The pool shall issue a certificate of insurability to an enrollee whose policy is~~
5675 ~~cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the~~
5676 ~~requirements of Subsection 31A-29-111(5) are met.~~

5677 (2) The pool may cancel an enrollee's policy at any time if:

5678 (a) the pool has provided written notice to the enrollee's last-known address no less
5679 than 15 days before cancellation; and

5680 (b) (i) the enrollee establishes a residency outside of Utah for three consecutive
5681 months;

5682 (ii) there is nonpayment of premiums; or

5683 (iii) the pool determines that the enrollee does not meet the eligibility requirements set
5684 forth in Section 31A-29-111, in which case:

5685 (A) the policy may be retroactively terminated for the period of time in which the
5686 enrollee was not eligible;

5687 (B) retroactive termination may not exceed three years; and

5688 (C) the board's remedy under this Subsection (2)(b) shall be a cause of action against
5689 the enrollee for benefits paid during the period of ineligibility in accordance with Subsection
5690 31A-29-119(3).

5691 Section 49. Section 31A-30-102 is amended to read:

5692 **31A-30-102. Purpose statement.**

5693 The purpose of this chapter is to:

5694 (1) prevent abusive rating practices;

5695 (2) require disclosure of rating practices to purchasers;

5696 (3) establish rules regarding:

5697 (a) a universal individual and small group application; and

5698 (b) renewability of coverage;

5699 (4) improve the overall fairness and efficiency of the individual and small group
5700 insurance market;

5701 (5) provide increased access for individuals and small employers to health insurance;
5702 and

5703 (6) provide an employer with the opportunity to establish a defined contribution
5704 arrangement for an employee to purchase a health benefit plan through the [~~Internet portal~~]
5705 Health Insurance Exchange created by Section [63M-1-2504](#).

5706 Section 50. Section **31A-30-103** is amended to read:

5707 **31A-30-103. Definitions.**

5708 As used in this chapter:

5709 (1) "Actuarial certification" means a written statement by a member of the American
5710 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
5711 is in compliance with [~~Sections [31A-30-106](#) and [31A-30-106.1](#)~~] this chapter, based upon the
5712 examination of the covered carrier, including review of the appropriate records and of the
5713 actuarial assumptions and methods used by the covered carrier in establishing premium rates
5714 for applicable health benefit plans.

5715 (2) "Affiliate" or "affiliated" means [~~any entity or~~] a person who directly or indirectly
5716 through one or more intermediaries, controls or is controlled by, or is under common control
5717 with, a specified [~~entity or~~] person.

5718 (3) "Base premium rate" means, for each class of business as to a rating period, the
5719 lowest premium rate charged or that could have been charged under a rating system for that
5720 class of business by the covered carrier to covered insureds with similar case characteristics for
5721 health benefit plans with the same or similar coverage.

5722 (4) (a) "Bona fide employer association" means an association of employers:

5723 (i) that meets the requirements of Subsection [31A-22-701\(2\)\(b\)](#);

5724 (ii) in which the employers of the association, either directly or indirectly, exercise
5725 control over the plan;

5726 (iii) that is organized:

5727 (A) based on a commonality of interest between the employers and their employees
5728 that participate in the plan by some common economic or representation interest or genuine
5729 organizational relationship unrelated to the provision of benefits; and

5730 (B) to act in the best interests of its employers to provide benefits for the employer's
5731 employees and their spouses and dependents, and other benefits relating to employment; and

5732 (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

5733 (b) The commissioner shall consider the following with regard to determining whether
5734 an association of employers is a bona fide employer association under Subsection (4)(a):

5735 (i) how association members are solicited;

5736 (ii) who participates in the association;

5737 (iii) the process by which the association was formed;

5738 (iv) the purposes for which the association was formed, and what, if any, were the
5739 pre-existing relationships of its members;

5740 (v) the powers, rights and privileges of employer members; and

5741 (vi) who actually controls and directs the activities and operations of the benefit
5742 programs.

5743 (5) "Carrier" means ~~[any]~~ a person ~~[or entity]~~ that provides health insurance in this
5744 state including:

5745 (a) an insurance company;

5746 (b) a prepaid hospital or medical care plan;

5747 (c) a health maintenance organization;

5748 (d) a multiple employer welfare arrangement; and

5749 (e) ~~[any other]~~ another person ~~[or entity]~~ providing a health insurance plan under this
5750 title.

5751 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
5752 demographic or other objective characteristics of a covered insured that are considered by the
5753 carrier in determining premium rates for the covered insured.

5754 (b) "Case characteristics" do not include:

5755 (i) duration of coverage since the policy was issued;

5756 (ii) claim experience; and

5757 (iii) health status.

5758 (7) "Class of business" means all or a separate grouping of covered insureds that is
5759 permitted by the commissioner in accordance with Section [31A-30-105](#).

5760 ~~[(8) "Conversion policy" means a policy providing coverage under the conversion~~

5761 ~~provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.]~~

5762 ~~[(9)]~~ (8) "Covered carrier" means ~~[any]~~ an individual carrier or small employer carrier
5763 subject to this chapter.

5764 ~~[(10)]~~ (9) "Covered individual" means ~~[any]~~ an individual who is covered under a
5765 health benefit plan subject to this chapter.

5766 ~~[(11)]~~ (10) "Covered insureds" means small employers and individuals who are issued
5767 a health benefit plan that is subject to this chapter.

5768 ~~[(12)]~~ (11) "Dependent" means an individual to the extent that the individual is defined
5769 to be a dependent by:

5770 (a) the health benefit plan covering the covered individual; and

5771 (b) Chapter 22, Part 6, Accident and Health Insurance.

5772 ~~[(13)]~~ (12) "Established geographic service area" means a geographical area approved
5773 by the commissioner within which the carrier is authorized to provide coverage.

5774 ~~[(14)]~~ (13) "Index rate" means, for each class of business as to a rating period for
5775 covered insureds with similar case characteristics, the arithmetic average of the applicable base
5776 premium rate and the corresponding highest premium rate.

5777 ~~[(15)]~~ (14) "Individual carrier" means a carrier that provides coverage on an individual
5778 basis through a health benefit plan regardless of whether:

5779 (a) coverage is offered through:

5780 (i) an association;

5781 (ii) a trust;

5782 (iii) a discretionary group; or

5783 (iv) other similar groups; or

5784 (b) the policy or contract is situated out-of-state.

5785 ~~[(16)]~~ (15) "Individual conversion policy" means a conversion policy issued to:

5786 (a) an individual; or

5787 (b) an individual with a family.

5788 ~~[(17)] "Individual coverage count" means the number of natural persons covered under~~
5789 ~~a carrier's health benefit products that are individual policies.]~~

5790 ~~[(18)] "Individual enrollment cap" means the percentage set by the commissioner in~~
5791 ~~accordance with Section [31A-30-110](#).]~~

5792 ~~[(19)]~~ (16) "New business premium rate" means, for each class of business as to a
5793 rating period, the lowest premium rate charged or offered, or that could have been charged or
5794 offered, by the carrier to covered insureds with similar case characteristics for newly issued
5795 health benefit plans with the same or similar coverage.

5796 ~~[(20)]~~ (17) "Premium" means money paid by covered insureds and covered individuals
5797 as a condition of receiving coverage from a covered carrier, including ~~[any]~~ fees or other
5798 contributions associated with the health benefit plan.

5799 ~~[(21)]~~ (18) (a) "Rating period" means the calendar period for which premium rates
5800 established by a covered carrier are assumed to be in effect, as determined by the carrier.

5801 (b) A covered carrier may not have:

5802 (i) more than one rating period in any calendar month; and

5803 (ii) no more than 12 rating periods in any calendar year.

5804 ~~[(22) "Resident" means an individual who has resided in this state for at least 12
5805 consecutive months immediately preceding the date of application.]~~

5806 ~~[(23)]~~ (19) "Short-term limited duration insurance" means a health benefit product that:

5807 (a) is not renewable; and

5808 (b) has an expiration date specified in the contract that is less than 364 days after the
5809 date the plan became effective.

5810 ~~[(24)]~~ (20) "Small employer carrier" means a carrier that provides health benefit plans
5811 covering eligible employees of one or more small employers in this state, regardless of
5812 whether:

5813 (a) coverage is offered through:

5814 (i) an association;

5815 (ii) a trust;

5816 (iii) a discretionary group; or

5817 (iv) other similar grouping; or

5818 (b) the policy or contract is situated out-of-state.

5819 ~~[(25) "Uninsurable" means an individual who:]~~

5820 ~~[(a) is eligible for the Comprehensive Health Insurance Pool coverage under the
5821 underwriting criteria established in Subsection 31A-29-11(5); or]~~

5822 ~~[(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and]~~

5823 ~~[(ii) has a condition of health that does not meet consistently applied underwriting~~
5824 ~~criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g)~~
5825 ~~and (h) for which coverage the applicant is applying.]~~

5826 ~~[(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for~~
5827 ~~purposes of this formula:]~~

5828 ~~[(a) "CI" means the carrier's individual coverage count as of December 31 of the~~
5829 ~~preceding year; and]~~

5830 ~~[(b) "UC" means the number of uninsurable individuals who were issued an individual~~
5831 ~~policy on or after July 1, 1997.]~~

5832 Section 51. Section 31A-30-104 is amended to read:

5833 **31A-30-104. Applicability and scope.**

5834 (1) This chapter applies to any:

5835 (a) health benefit plan that provides coverage to:

5836 (i) individuals;

5837 (ii) small employers, except as provided in Subsection (3); or

5838 (iii) both Subsections (1)(a)(i) and (ii); or

5839 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
5840 31A-30-107.5.

5841 (2) This chapter applies to a health benefit plan that provides coverage to small
5842 employers or individuals regardless of:

5843 (a) whether the contract is issued to:

5844 (i) an association, except as provided in Subsection (3);

5845 (ii) a trust;

5846 (iii) a discretionary group; or

5847 (iv) other similar grouping; or

5848 (b) the situs of delivery of the policy or contract.

5849 (3) This chapter does not apply to:

5850 (a) short-term limited duration health insurance;

5851 (b) federally funded or partially funded programs; or

5852 (c) a bona fide employer association.

5853 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

5854 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
5855 return shall be treated as one carrier; and

5856 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
5857 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
5858 carriers were issued by one carrier.

5859 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
5860 maintenance organization having a certificate of authority under this title may be considered to
5861 be a separate carrier for the purposes of this chapter.

5862 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined
5863 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding
5864 arrangements with respect to health benefit plans delivered or issued for delivery to covered
5865 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
5866 obligation or risk for the health benefit plans being retained by the ceding carrier.

5867 (d) Section [31A-22-1201](#) applies if a covered carrier cedes or assumes all of the
5868 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
5869 for delivery to covered insureds in this state.

5870 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
5871 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
5872 may make a written request to the commissioner for a waiver from the application of any of the
5873 provisions of ~~[Subsection]~~ [Subsections 31A-30-106\(1\) and 31A-30-106.1\(1\)](#) with respect to a
5874 health benefit plan provided to the trust.

5875 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
5876 waiver if the commissioner finds that application with respect to the trust would:

5877 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
5878 and

5879 (ii) require significant modifications to one or more collective bargaining arrangements
5880 under which the trust is established or maintained.

5881 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
5882 person participates in a Taft Hartley trust as an associate member of any employee
5883 organization.

5884 (6) Sections [31A-30-106](#), [31A-30-106.1](#), [31A-30-106.5](#), [31A-30-106.7](#), [31A-30-107](#),

5885 and 31A-30-108, [~~and 31A-30-111~~] apply to:

5886 (a) any insurer engaging in the business of insurance related to the risk of a small
5887 employer for medical, surgical, hospital, or ancillary health care expenses of the small
5888 employer's employees provided as an employee benefit; and

5889 (b) any contract of an insurer, other than a workers' compensation policy, related to the
5890 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the
5891 small employer's employees provided as an employee benefit.

5892 (7) The commissioner may make rules requiring that the marketing practices be
5893 consistent with this chapter for:

5894 (a) a small employer carrier;

5895 (b) a small employer carrier's agent;

5896 (c) an insurance producer;

5897 (d) an insurance consultant; and

5898 (e) a navigator.

5899 Section 52. Section **31A-30-106** is amended to read:

5900 **31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.**

5901 (1) Premium rates for health benefit plans for individuals under this chapter are subject
5902 to this section.

5903 (a) The index rate for a rating period for any class of business may not exceed the
5904 index rate for any other class of business by more than 20%.

5905 (b) (i) For a class of business, the premium rates charged during a rating period to
5906 covered insureds with similar case characteristics for the same or similar coverage, or the rates
5907 that could be charged to the individual under the rating system for that class of business, may
5908 not vary from the index rate by more than 30% of the index rate except as provided under
5909 Subsection (1)(b)(ii).

5910 (ii) A carrier that offers individual and small employer health benefit plans may use the
5911 small employer index rates to establish the rate limitations for individual policies, even if some
5912 individual policies are rated below the small employer base rate.

5913 (c) The percentage increase in the premium rate charged to a covered insured for a new
5914 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
5915 the following:

5916 (i) the percentage change in the new business premium rate measured from the first day
5917 of the prior rating period to the first day of the new rating period;

5918 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
5919 of less than one year, due to the claim experience, health status, or duration of coverage of the
5920 covered individuals as determined from the rate manual for the class of business of the carrier
5921 offering an individual health benefit plan; and

5922 (iii) any adjustment due to change in coverage or change in the case characteristics of
5923 the covered insured as determined from the rate manual for the class of business of the carrier
5924 offering an individual health benefit plan.

5925 (d) (i) A carrier offering an individual health benefit plan shall apply rating factors,
5926 including case characteristics, consistently with respect to all covered insureds in a class of
5927 business.

5928 (ii) Rating factors shall produce premiums for identical individuals that:

5929 (A) differ only by the amounts attributable to plan design; and

5930 (B) do not reflect differences due to the nature of the individuals assumed to select
5931 particular health benefit products.

5932 (iii) A carrier offering an individual health benefit plan shall treat all health benefit
5933 plans issued or renewed in the same calendar month as having the same rating period.

5934 (e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted
5935 network provision may not be considered similar coverage to a health benefit plan that does not
5936 use a restricted network provision, provided that use of the restricted network provision results
5937 in substantial difference in claims costs.

5938 (f) A carrier offering a health benefit plan to an individual may not, without prior
5939 approval of the commissioner, use case characteristics other than:

5940 (i) age;

5941 (ii) gender;

5942 (iii) geographic area; and

5943 (iv) family composition.

5944 (g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3,
5945 Utah Administrative Rulemaking Act, to:

5946 (A) implement this chapter; [and]

5947 (B) assure that rating practices used by carriers who offer health benefit plans to
 5948 individuals are consistent with the purposes of this chapter[-]; and

5949 (C) promote transparency of rating practices of health benefit plans, except that a
 5950 carrier may not be required to disclose proprietary information.

5951 (ii) The rules described in Subsection (1)(g)(i) may include rules that:

5952 (A) assure that differences in rates charged for health benefit products by carriers who
 5953 offer health benefit plans to individuals are reasonable and reflect objective differences in plan
 5954 design, not including differences due to the nature of the individuals assumed to select
 5955 particular health benefit products; and

5956 (B) prescribe the manner in which case characteristics may be used by carriers who
 5957 offer health benefit plans to individuals[;].

5958 [~~(C) implement the individual enrollment cap under Section 31A-30-110, including~~
 5959 ~~specifying:]~~

5960 [~~(F) the contents for certification;]~~

5961 [~~(H) auditing standards;]~~

5962 [~~(III) underwriting criteria for uninsurable classification; and]~~

5963 [~~(IV) limitations on high risk enrollees under Section 31A-30-111; and]~~

5964 [~~(D) establish the individual enrollment cap under Subsection 31A-30-110(1).]~~

5965 [~~(h) Before implementing regulations for underwriting criteria for uninsurable~~
 5966 ~~classification, the commissioner shall contract with an independent consulting organization to~~
 5967 ~~develop industry-wide underwriting criteria for uninsurability based on an individual's expected~~
 5968 ~~claims under open enrollment coverage exceeding 325% of that expected for a standard~~
 5969 ~~insurable individual with the same case characteristics.]~~

5970 [~~(i)~~] (h) The commissioner shall revise rules issued for Sections 31A-22-602 and
 5971 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance
 5972 with this section.

5973 (2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit
 5974 product into which the covered carrier is no longer enrolling new covered insureds, the covered
 5975 carrier shall use the percentage change in the base premium rate, provided that the change does
 5976 not exceed, on a percentage basis, the change in the new business premium rate for the most
 5977 similar health benefit product into which the covered carrier is actively enrolling new covered

5978 insureds.

5979 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of
5980 a class of business.

5981 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
5982 of business unless the offer is made to transfer all covered insureds in the class of business
5983 without regard to:

5984 (i) case characteristics;

5985 (ii) claim experience;

5986 (iii) health status; or

5987 (iv) duration of coverage since issue.

5988 (4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the
5989 carrier's principal place of business a complete and detailed description of its rating practices
5990 and renewal underwriting practices, including information and documentation that demonstrate
5991 that the carrier's rating methods and practices are:

5992 (i) based upon commonly accepted actuarial assumptions; and

5993 (ii) in accordance with sound actuarial principles.

5994 (b) (i) ~~Each~~ A carrier subject to this section shall file with the commissioner, on or
5995 before April 1 of each year, in a form, manner, and containing such information as prescribed
5996 by the commissioner, an actuarial certification certifying that:

5997 (A) the carrier is in compliance with this chapter; and

5998 (B) the rating methods of the carrier are actuarially sound.

5999 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the
6000 carrier at the carrier's principal place of business.

6001 (c) A carrier shall make the information and documentation described in this
6002 Subsection (4) available to the commissioner upon request.

6003 (d) ~~Records~~ Except as provided in Subsection (1)(g) or required by PPACA, a record
6004 submitted to the commissioner under this section shall be maintained by the commissioner as a
6005 protected ~~records~~ record under Title 63G, Chapter 2, Government Records Access and
6006 Management Act.

6007 Section 53. Section **31A-30-106.7** is amended to read:

6008 **31A-30-106.7. Surcharge for groups changing carriers.**

6009 (1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered
6010 carrier may impose upon a small group that changes coverage to that carrier from another
6011 carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could
6012 otherwise charge under Section [~~31A-30-106~~] 31A-30-106.1.

6013 (b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

6014 (i) the change in carriers occurs on the anniversary of the plan year, as defined in
6015 Section 31A-1-301;

6016 (ii) the previous coverage was terminated under Subsection 31A-30-107(3)(e); ~~or~~

6017 (iii) employees from an existing group form a new business~~[-]~~; and

6018 (iv) the surcharge is not applied uniformly to all similarly situated small groups.

6019 (2) A covered carrier may not impose the surcharge described in Subsection (1) if the
6020 offer to cover the group occurs at a time other than the anniversary of the plan year because:

6021 (a) (i) the application for coverage is made prior to the anniversary date in accordance
6022 with the covered carrier's published policies; and

6023 (ii) the offer to cover the group is not issued until after the anniversary date; or

6024 (b) (i) the application for coverage is made prior to the anniversary date in accordance
6025 with the covered carrier's published policies; and

6026 (ii) additional underwriting or rating information requested by the covered carrier is not
6027 received until after the anniversary date.

6028 (3) If a covered carrier chooses to apply a surcharge under Subsection (1), the
6029 application of the surcharge and the criteria for incurring or avoiding the surcharge shall be
6030 clearly stated in the:

6031 (a) written application materials provided to the applicant at the time of application;
6032 and

6033 (b) written producer guidelines.

6034 (4) The commissioner shall adopt rules in accordance with Title 63G, Chapter 3, Utah
6035 Administrative Rulemaking Act, to ensure compliance with this section.

6036 Section 54. Section 31A-30-107 is amended to read:

6037 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
6038 **nonrenewal.**

6039 (1) Except as otherwise provided in this section, a small employer health benefit plan is

6040 renewable and continues in force:

6041 (a) with respect to all eligible employees and dependents; and

6042 (b) at the option of the plan sponsor.

6043 (2) A small employer health benefit plan may be discontinued or nonrenewed:

6044 (a) for a network plan, if~~[-(†)]~~ there is no longer any enrollee under the group health
6045 plan who lives, resides, or works in:

6046 ~~[(A)]~~ (i) the service area of the covered carrier; or

6047 ~~[(B)]~~ (ii) the area for which the covered carrier is authorized to do business; ~~[and]~~ or

6048 ~~[(ii) in the case of the small employer market, the small employer carrier applies the~~
6049 ~~same criteria the small employer carrier would apply in denying enrollment in the plan under~~
6050 ~~Subsection 31A-30-108(7); or]~~

6051 (b) for coverage made available in the small or large employer market only through an
6052 association, if:

6053 (i) the employer's membership in the association ceases; and

6054 (ii) the coverage is terminated uniformly without regard to any health status-related
6055 factor relating to any covered individual.

6056 (3) A small employer health benefit plan may be discontinued if:

6057 (a) a condition described in Subsection (2) exists;

6058 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay
6059 premiums or contributions in accordance with the terms of the contract;

6060 (c) the plan sponsor:

6061 (i) performs an act or practice that constitutes fraud; or

6062 (ii) makes an intentional misrepresentation of material fact under the terms of the
6063 coverage;

6064 (d) the covered carrier:

6065 (i) elects to discontinue offering a particular small employer health benefit product
6066 delivered or issued for delivery in this state; and

6067 (ii) (A) provides notice of the discontinuation in writing:

6068 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

6069 (II) at least 90 days before the date the coverage will be discontinued;

6070 (B) provides notice of the discontinuation in writing:

- 6071 (I) to the commissioner; and
- 6072 (II) at least three working days prior to the date the notice is sent to the affected plan
6073 sponsors, employees, and dependents of the plan sponsors or employees;
- 6074 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all
6075 other small employer health benefit products currently being offered by the small employer
6076 carrier in the market; and
- 6077 (D) in exercising the option to discontinue that product and in offering the option of
6078 coverage in this section, acts uniformly without regard to:
- 6079 (I) the claims experience of a plan sponsor;
- 6080 (II) any health status-related factor relating to any covered participant or beneficiary; or
- 6081 (III) any health status-related factor relating to any new participant or beneficiary who
6082 may become eligible for the coverage; or
- 6083 (e) the covered carrier:
- 6084 (i) elects to discontinue all of the covered carrier's small employer health benefit plans
6085 in:
- 6086 (A) the small employer market;
- 6087 (B) the large employer market; or
- 6088 (C) both the small employer and large employer markets; and
- 6089 (ii) (A) provides notice of the discontinuation in writing:
- 6090 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
- 6091 (II) at least 180 days before the date the coverage will be discontinued;
- 6092 (B) provides notice of the discontinuation in writing:
- 6093 (I) to the commissioner in each state in which an affected insured individual is known
6094 to reside; and
- 6095 (II) at least 30 working days prior to the date the notice is sent to the affected plan
6096 sponsors, employees, and the dependents of the plan sponsors or employees;
- 6097 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
6098 market; and
- 6099 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
- 6100 (4) A small employer health benefit plan may be discontinued or nonrenewed:
- 6101 (a) if a condition described in Subsection (2) exists; or

6102 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
6103 employer contribution requirements.

6104 (5) A small employer health benefit plan may be nonrenewed:

6105 (a) if a condition described in Subsection (2) exists; or

6106 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
6107 minimum participation requirements.

6108 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
6109 discontinued if after issuance of coverage the eligible employee:

6110 (i) engages in an act or practice that constitutes fraud in connection with the coverage;

6111 or

6112 (ii) makes an intentional misrepresentation of material fact in connection with the
6113 coverage.

6114 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

6115 (i) 12 months after the date of discontinuance; and

6116 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
6117 to reenroll.

6118 (c) At the time the eligible employee's coverage is discontinued under Subsection
6119 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
6120 coverage is discontinued.

6121 (d) An eligible employee may not be discontinued under this Subsection (6) because of
6122 a fraud or misrepresentation that relates to health status.

6123 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
6124 the employer:

6125 (a) with respect to coverage provided to an employer member of the association; and

6126 (b) if the small employer health benefit plan is made available by a covered carrier in
6127 the employer market only through:

6128 (i) an association;

6129 (ii) a trust; or

6130 (iii) a discretionary group.

6131 (8) A covered carrier may modify a small employer health benefit plan only:

6132 (a) at the time of coverage renewal; and

6133 (b) if the modification is effective uniformly among all plans with that product.

6134 Section 55. Section **31A-30-108** is amended to read:

6135 **31A-30-108. Eligibility for small employer and individual market.**

6136 (1) (a) ~~[Small employer carriers shall accept residents]~~ A small employer carrier shall
 6137 accept a small employer that applies for small group coverage as set forth in the Health
 6138 Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a), and PPACA, Sec.
 6139 2702.

6140 ~~[(b) Individual carriers shall accept residents for individual coverage pursuant to:]~~

6141 ~~[(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and]~~

6142 ~~[(ii) Subsection (3).]~~

6143 (b) An individual carrier shall accept an individual that applies for individual coverage
 6144 as set forth in PPACA, Sec. 2702.

6145 (2) (a) ~~[Small]~~ A small employer ~~[carriers]~~ carrier shall offer to accept all eligible
 6146 employees and their dependents at the same level of benefits under any health benefit plan
 6147 provided to a small employer.

6148 (b) ~~[Small]~~ A small employer ~~[carriers]~~ carrier may:

6149 (i) request a small employer to submit a copy of the small employer's quarterly income
 6150 tax withholdings to determine whether the employees for whom coverage is provided or
 6151 requested are bona fide employees of the small employer; and

6152 (ii) deny or terminate coverage if the small employer refuses to provide documentation
 6153 requested under Subsection (2)(b)(i).

6154 ~~[(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual~~
 6155 ~~carriers shall accept for coverage individuals to whom all of the following conditions apply:]~~

6156 ~~[(a) the individual is not covered or eligible for coverage:]~~

6157 ~~[(i) (A) as an employee of an employer;]~~

6158 ~~[(B) as a member of an association; or]~~

6159 ~~[(C) as a member of any other group; and]~~

6160 ~~[(ii) under:]~~

6161 ~~[(A) a health benefit plan; or]~~

6162 ~~[(B) a self-insured arrangement that provides coverage similar to that provided by a~~
 6163 ~~health benefit plan as defined in Section 31A-1-301;]~~

6164 ~~[(b) the individual is not covered and is not eligible for coverage under any public~~
6165 ~~health benefits arrangement including:]~~

6166 ~~[(i) the Medicare program established under Title XVIII of the Social Security Act;]~~
6167 ~~[(ii) any act of Congress or law of this or any other state that provides benefits~~
6168 ~~comparable to the benefits provided under this chapter; or]~~

6169 ~~[(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter~~
6170 ~~29, Comprehensive Health Insurance Pool Act;]~~

6171 ~~[(c) unless the maximum benefit has been reached the individual is not covered or~~
6172 ~~eligible for coverage under any:]~~

6173 ~~[(i) Medicare supplement policy;]~~
6174 ~~[(ii) conversion option;]~~
6175 ~~[(iii) continuation or extension under COBRA; or]~~
6176 ~~[(iv) state extension;]~~

6177 ~~[(d) the individual has not terminated or declined coverage described in Subsection~~
6178 ~~(3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for~~
6179 ~~individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b),~~
6180 ~~in which case, the requirement of this Subsection (3)(d) does not apply; and]~~

6181 ~~[(e) the individual is certified as ineligible for the Health Insurance Pool if:]~~

6182 ~~[(i) the individual applies for coverage with the Comprehensive Health Insurance Pool~~
6183 ~~within 30 days after being rejected or refused coverage by the covered carrier and reapplies for~~
6184 ~~coverage with that covered carrier within 30 days after the date of issuance of a certificate~~
6185 ~~under Subsection [31A-29-111\(5\)\(c\)](#); or]~~

6186 ~~[(ii) the individual applies for coverage with any individual carrier within 45 days~~
6187 ~~after:]~~

6188 ~~[(A) notice of cancellation of coverage under Subsection [31A-29-115\(1\)](#); or]~~
6189 ~~[(B) the date of issuance of a certificate under Subsection [31A-29-111\(5\)\(c\)](#) if the~~
6190 ~~individual applied first for coverage with the Comprehensive Health Insurance Pool;]~~

6191 ~~[(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is~~
6192 ~~paid, the effective date of coverage shall be the first day of the month following the individual's~~
6193 ~~submission of a completed insurance application to that covered carrier.]~~

6194 ~~[(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is~~

6195 paid, the effective date of coverage shall be the day following the:]
6196 [(i) cancellation of coverage under Subsection 31A-29-115(1); or]
6197 [(ii) submission of a completed insurance application to the Comprehensive Health
6198 Insurance Pool.]
6199 [(5) (a) An individual carrier is not required to accept individuals for coverage under
6200 Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.]
6201 [(b) A carrier described in Subsection (5)(a) may not issue new individual policies in
6202 the state for five years from July 1, 1997.]
6203 [(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new
6204 policies after July 1, 1999, which may only be granted if:]
6205 [(i) the carrier accepts uninsurables as is required of a carrier entering the market under
6206 Subsection 31A-30-110; and]
6207 [(ii) the commissioner finds that the carrier's issuance of new individual policies:]
6208 [(A) is in the best interests of the state; and]
6209 [(B) does not provide an unfair advantage to the carrier.]
6210 [(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29,
6211 Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is
6212 capped or suspended, an individual carrier may decline to accept individuals applying for
6213 individual enrollment, other than individuals applying for coverage as set forth in Health
6214 Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).]
6215 [(b) Within two calendar days of taking action under Subsection (6)(a), an individual
6216 carrier will provide written notice to the department.]
6217 [(7) (a) If a small employer carrier offers health benefit plans to small employers
6218 through a network plan, the small employer carrier may:]
6219 [(i) limit the employers that may apply for the coverage to those employers with
6220 eligible employees who live, reside, or work in the service area for the network plan; and]
6221 [(ii) within the service area of the network plan, deny coverage to an employer if the
6222 small employer carrier has demonstrated to the commissioner that the small employer carrier:]
6223 [(A) will not have the capacity to deliver services adequately to enrollees of any
6224 additional groups because of the small employer carrier's obligations to existing group contract
6225 holders and enrollees; and]

6226 ~~[(B) applies this section uniformly to all employers without regard to:]~~
6227 ~~[(F) the claims experience of an employer, an employer's employee, or a dependent of~~
6228 ~~an employee; or]~~
6229 ~~[(H) any health status-related factor relating to an employee or dependent of an~~
6230 ~~employee.]~~
6231 ~~[(b) (i) A small employer carrier that denies a health benefit product to an employer in~~
6232 ~~any service area in accordance with this section may not offer coverage in the small employer~~
6233 ~~market within the service area to any employer for a period of 180 days after the date the~~
6234 ~~coverage is denied.]~~
6235 ~~[(ii) This Subsection (7)(b) does not:]~~
6236 ~~[(A) limit the small employer carrier's ability to renew coverage that is in force; or]~~
6237 ~~[(B) relieve the small employer carrier of the responsibility to renew coverage that is in~~
6238 ~~force.]~~
6239 ~~[(c) Coverage offered within a service area after the 180-day period specified in~~
6240 ~~Subsection (7)(b) is subject to the requirements of this section.]~~
6241 Section 56. Section **31A-30-207** is amended to read:
6242 **31A-30-207. Rating and underwriting restrictions for health plans in the defined**
6243 **contribution arrangement market.**
6244 (1) Except as provided in Subsection (2), rating and underwriting restrictions for
6245 defined contribution arrangement health benefit plans offered in the Health Insurance
6246 Exchange shall be in accordance with Section **31A-30-106.1**, and the plan adopted under
6247 Chapter 42, Defined Contribution Risk Adjuster Act.
6248 (2) Notwithstanding ~~[the provisions of]~~ Subsections **31A-30-106.1**(9)(b)(ii) and (iii), a
6249 carrier offering a defined contribution arrangement in the Health Insurance Exchange under
6250 this part~~[-(a)]~~ shall calculate rates based on a family tier rating structure that includes four tiers
6251 in compliance with Subsection **31A-30-106.1**(9)(b)(i)~~[-and]~~.
6252 ~~[(b) may not calculate rates based on a family tier rating structure that includes five or~~
6253 ~~six tiers as described in Subsection **31A-30-106**(9)(b)(ii) or (iii).]~~
6254 (3) All insurers who participate in the defined contribution market shall:
6255 (a) participate in the risk adjuster mechanism developed under Chapter 42, Defined
6256 Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

- 6257 (b) provide the risk adjuster board with:
- 6258 (i) an employer group's risk factor; and
- 6259 (ii) carrier enrollment data; and
- 6260 (c) submit rates to the exchange that are net of commissions.
- 6261 (4) When an employer group enters the defined contribution arrangement market and
- 6262 the employer group has a health plan with an insurer who is participating in the defined
- 6263 contribution arrangement market, the risk factor applied to the employer group when it enters
- 6264 the defined contribution arrangement market may not be greater than the employer group's
- 6265 renewal risk factor for the same group of covered employees and the same effective date, as
- 6266 determined by the employer group's insurer.

6267 Section 57. Section **31A-30-209** is amended to read:

6268 **31A-30-209. Insurance producers and the Health Insurance Exchange.**

6269 (1) A producer may be listed on the Health Insurance Exchange as a credentialed

6270 producer [~~for the defined contribution arrangement market in accordance with Section~~

6271 ~~63M-1-2504;~~] if the producer is designated as [~~an appointed~~] a credentialed agent for the

6272 [~~defined contribution arrangement market~~] Health Insurance Exchange in accordance with

6273 Subsection (2).

6274 (2) A producer whose license under this title authorizes the producer to sell [~~defined~~

6275 ~~contribution arrangement health benefit plans may be appointed to the defined contribution~~

6276 ~~arrangement market on~~] accident and health insurance may be credentialed by the Health

6277 Insurance Exchange [~~by the Insurance Department~~] and may sell any product on the Health

6278 Insurance Exchange, if the producer:

6279 [~~(a) submits an application to the Insurance Department to be appointed as a producer~~

6280 ~~for the defined contribution arrangement market on the Health Insurance Exchange;~~]

6281 [~~(b) is an appointed agent in accordance with Subsection (3), for products offered in~~

6282 ~~the defined contribution arrangement market of the Health Insurance Exchange, with the~~

6283 ~~carriers that offer a defined contribution arrangement health benefit plan on the Health~~

6284 ~~Insurance Exchange; and]~~

6285 [~~(c) has completed continuing education for the defined contribution arrangement~~

6286 ~~market that;~~]

6287 [~~(i) is required by administrative rule adopted by the commissioner; and]~~

6288 ~~[(ii) provides training on premium assistance programs:]~~

6289 (a) is an appointed producer with:

6290 (i) all carriers that offer a plan in the defined contribution market on the Health

6291 Insurance Exchange; and

6292 (ii) at least one carrier that offers a dental plan on the Health Insurance Exchange; and

6293 (b) completes each year the Health Insurance Exchange training that includes training

6294 on premium assistance programs.

6295 (3) A carrier shall appoint a producer to sell the carrier's products in the defined
6296 contribution arrangement market of the Health Insurance Exchange, within 30 days of the
6297 notice required in Subsection (3)(b), if:

6298 (a) the producer is currently appointed by a majority of the carriers in the Health
6299 Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange;
6300 and

6301 (b) the producer informs the carrier that the producer is:

6302 (i) applying to be appointed to the defined contribution arrangement market in the
6303 Health Insurance Exchange;

6304 (ii) appointed by a majority of the carriers in the defined contribution arrangement
6305 market in the Health Insurance Exchange;

6306 (iii) willing to complete training regarding the carrier's products offered on the defined
6307 contribution arrangement market in the Health Insurance Exchange; and

6308 (iv) willing to sign the contracts and business associate's agreements that the carrier
6309 requires for appointed producers in the Health Insurance Exchange.

6310 Section 58. Section **31A-30-211** is amended to read:

6311 **31A-30-211. Insurer disclosure.**

6312 ~~[(1) The Health Insurance Exchange shall provide an employer's producer with the~~
6313 ~~group's risk factor used to calculate the employer group's premium at the time of:]~~

6314 ~~[(a) the initial offering of a health benefit plan; and]~~

6315 ~~[(b) the renewal of a health benefit plan.]~~

6316 ~~[(2) For health benefit plans that renew on or after March 1, 2012:]~~

6317 (1) (a) [a] A carrier shall provide an employer and the employer's producer with
6318 premium renewal rates at least 60 days ~~[prior to]~~ before the group's renewal date for a plan

6319 offered under Part 1, Individual and Small Employer Group~~;~~ and].

6320 (b) ~~[the]~~ The Health Insurance Exchange shall provide an employer and the employer's
6321 producer with premium renewal rates at least 60 days ~~[prior to]~~ before the group's renewal date
6322 for a plan offered under Part 2, Defined Contribution Arrangements.

6323 ~~[(2)]~~ (2) An insurer does not have to provide additional notice of premium renewal
6324 rates to the employer or the employer's producer if the Health Insurance Exchange provides
6325 notice in accordance with Subsection ~~[(2)]~~ (1)(b).

6326 Section 59. Section **31A-37-501** is amended to read:

6327 **31A-37-501. Reports to commissioner.**

6328 (1) A captive insurance company is not required to make a report except those
6329 provided in this chapter.

6330 (2) (a) Before March 1 of each year, a captive insurance company shall submit to the
6331 commissioner a report of the financial condition of the captive insurance company, verified by
6332 oath of two of the executive officers of the captive insurance company.

6333 (b) Except as provided in Sections [31A-37-204](#) and [31A-37-205](#), a captive insurance
6334 company shall report:

6335 (i) using generally accepted accounting principles, except to the extent that the
6336 commissioner requires, approves, or accepts the use of a statutory accounting principle;

6337 (ii) using a useful or necessary modification or adaptation to an accounting principle
6338 that is required, approved, or accepted by the commissioner for the type of insurance and kind
6339 of insurer to be reported upon; and

6340 (iii) supplemental or additional information required by the commissioner.

6341 (c) Except as otherwise provided:

6342 (i) ~~[an association captive insurance company and an industrial insured group]~~ a
6343 licensed captive insurance company shall file the report required by Section [31A-4-113](#); and

6344 (ii) an industrial insured group shall comply with Section [31A-4-113.5](#).

6345 (3) (a) A pure captive insurance company may make written application to file the
6346 required report on a fiscal year end that is consistent with the fiscal year of the parent company
6347 of the pure captive insurance company.

6348 (b) If the commissioner grants an alternative reporting date for a pure captive insurance
6349 company requested under Subsection (3)(a), the annual report is due 60 days after the fiscal

6350 year end.

6351 (4) (a) Sixty days after the fiscal year end, a branch captive insurance company shall
6352 file with the commissioner a copy of [aH] the reports and statements required to be filed under
6353 the laws of the jurisdiction in which the alien captive insurance company is formed, verified by
6354 oath by two of the alien captive insurance company's executive officers.

6355 (b) If the commissioner is satisfied that the annual report filed by the alien captive
6356 insurance company in the jurisdiction in which the alien captive insurance company is formed
6357 provides adequate information concerning the financial condition of the alien captive insurance
6358 company, the commissioner may waive the requirement for completion of the annual statement
6359 required for a captive insurance company under this section with respect to business written in
6360 the alien jurisdiction.

6361 (c) A waiver by the commissioner under Subsection (4)(b):

6362 (i) shall be in writing; and

6363 (ii) is subject to public inspection.

6364 Section 60. Section **31A-40-203** is amended to read:

6365 **31A-40-203. Covered employee.**

6366 (1) (a) An individual is a covered employee of a professional employer organization if
6367 the individual is coemployed pursuant to a professional employer agreement subject to this
6368 chapter.

6369 (b) An individual who is a covered employee under a professional employer agreement
6370 is a covered [~~employer~~] employee, whether or not the professional employer organization
6371 provides the notice required by Subsection **31A-40-202**(3), the earlier of the day on which:

6372 (i) the employee is first compensated by the professional employer organization; or

6373 (ii) the client notifies the professional employer organization of a new hire.

6374 (2) An individual who is an officer, director, shareholder, partner, or manager of a
6375 client is a covered employee:

6376 (a) to the extent that the client and the professional employer organization expressly
6377 agree in the professional employer agreement that the individual is a covered employee;

6378 (b) if the conditions of Subsection (1) are met; and

6379 (c) if the individual acts as an operational manager or performs day-to-day an

6380 operational service for the client.

6381 Section 61. Section 31A-40-209 is amended to read:

6382 **31A-40-209. Workers' compensation.**

6383 (1) In accordance with Section 34A-2-103, a client is responsible for securing workers'
6384 compensation coverage for a covered employee.

6385 (2) Subject to the requirements of Section 34A-2-103, if a professional employer
6386 organization obtains or assists a client in obtaining workers' compensation insurance pursuant
6387 to a professional employer agreement:

6388 (a) the professional employer organization shall ensure that the client maintains and
6389 provides workers' compensation coverage for a covered employee in accordance with
6390 Subsection 34A-2-201(1) or (2) and rules of the Labor Commission, made in accordance with
6391 Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

6392 (b) the workers' compensation coverage may show the professional employer
6393 organization as the named insured through a [~~multiple coordinated~~] master policy, if:

6394 (i) the client is shown as an insured by means of an endorsement for each individual
6395 client;

6396 (ii) the experience modification of a client is used; and

6397 (iii) the insurer files the endorsement with the Division of Industrial Accidents as
6398 directed by a rule of the Labor Commission, made in accordance with Title 63G, Chapter 3,
6399 Utah Administrative Rulemaking Act;

6400 (c) at the termination of the professional employer agreement, if requested by the
6401 client, the insurer shall provide the client records regarding the loss experience related to
6402 workers' compensation insurance provided to a covered employee pursuant to the professional
6403 employer agreement; and

6404 (d) the insurer shall notify a client if the workers' compensation coverage for the client
6405 is terminated.

6406 (3) In accordance with Section 34A-2-105, the exclusive remedy provisions of Section
6407 34A-2-105 apply to both the client and the professional employer organization under a
6408 professional employer agreement regulated under this chapter.

6409 (4) Notwithstanding the other provisions in this section, an insurer may choose whether
6410 to issue:

6411 (a) a policy for a client; or

6412 (b) a [~~multiple-coordinated~~] master policy with the client shown as an additional
6413 insured by means of an individual endorsement.

6414 Section 62. Section **31A-42-202** is amended to read:

6415 **31A-42-202. Contents of plan.**

6416 (1) The board shall submit a plan of operation for the risk adjuster to the
6417 commissioner. The plan shall:

6418 (a) establish the methodology for implementing:

6419 (i) Subsection (2) for the defined contribution arrangement market established under
6420 Chapter 30, Part 2, Defined Contribution Arrangements; and

6421 (ii) the participation of small employer group defined contribution arrangement health
6422 benefit plans;

6423 (b) establish regular times and places for meetings of the board;

6424 (c) establish procedures for keeping records of all financial transactions and for
6425 sending annual fiscal reports to the commissioner;

6426 (d) contain additional provisions necessary and proper for the execution of the powers
6427 and duties of the risk adjuster; and

6428 (e) establish procedures in compliance with Title 63A, Utah Administrative Services
6429 Code, to pay for administrative expenses incurred.

6430 (2) (a) The plan adopted by the board for the defined contribution arrangement market
6431 shall include:

6432 (i) parameters an employer may use to designate eligible employees for the defined
6433 contribution arrangement market; and

6434 (ii) underwriting mechanisms and employer eligibility guidelines:

6435 (A) consistent with the federal Health Insurance Portability and Accountability Act;
6436 and

6437 (B) necessary to protect insurance carriers from adverse selection in the defined
6438 contribution market.

6439 (b) The plan required by Subsection (2)(a) shall outline how premium rates for a
6440 qualified individual in the defined contribution arrangement market are determined, including:

6441 (i) the identification of an initial rate for a qualified individual based on:

6442 (A) standardized age bands submitted by participating insurers; and

6443 (B) wellness incentives for the individual as permitted by federal law; and
6444 (ii) the identification of a group risk factor to be applied to the initial age rate of a
6445 qualified individual based on the health conditions of all qualified individuals in the same
6446 employer group and, for small employers, in accordance with Sections 31A-30-105 and
6447 31A-30-106.1.

6448 (c) The plan adopted under Subsection (2)(a) for the defined contribution arrangement
6449 market shall outline how:

6450 (i) premium contributions for qualified individuals shall be submitted to the Health
6451 Insurance Exchange in the amount determined under Subsection (2)(b); and

6452 (ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by
6453 qualified individuals within an employer group based on each individual's rating factor
6454 determined in accordance with the plan.

6455 (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting
6456 risk between defined contribution arrangement market insurers that:

6457 (i) identifies health care conditions subject to risk adjustment;

6458 (ii) establishes an adjustment amount for each identified health care condition;

6459 (iii) determines the extent to which an insurer has more or less individuals with an
6460 identified health condition than would be expected; and

6461 (iv) computes all risk adjustments.

6462 (e) The board may amend the plan if necessary to:

6463 (i) maintain the proper functioning and solvency of the defined contribution
6464 arrangement market and the risk adjuster mechanism;

6465 (ii) mitigate significant issues of risk selection; or

6466 (iii) improve the administration of the risk adjuster mechanism.

6467 (3) The board shall establish a mechanism in which the defined contribution
6468 arrangement market participating carriers shall submit their plan base rates, rating factors, and
6469 premiums to the commissioner for an actuarial review under ~~[the provisions of]~~ Section
6470 31A-30-115 ~~[prior to]~~ before the publication of the premium rates on the Health Insurance
6471 Exchange.

6472 Section 63. Section 31A-43-102 is amended to read:
6473 **31A-43-102. Definitions.**

6474 For purposes of this chapter:

6475 (1) "Actuarial certification" means a written statement by a member of the American
6476 Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer
6477 is in compliance with ~~[the provisions of]~~ this chapter, based upon the individual's examination
6478 and including a review of the appropriate records and the actuarial assumptions and methods
6479 used by the stop-loss insurer in establishing attachment points and other applicable
6480 determinations in conjunction with the provision of stop-loss insurance coverage.

6481 (2) "Aggregate attachment point" means the dollar amount ~~[in losses for eligible~~
6482 ~~expenses]~~ of covered claims incurred by a small employer plan beyond which the stop-loss
6483 insurer incurs liability for ~~[all or part of the]~~ losses incurred by the small employer plan, subject
6484 to limitations included in the contract.

6485 (3) "Coverage" means the combination of the employer plan design and the stop-loss
6486 contract design.

6487 (4) "Expected claims" means the amount of claims that, in the absence of ~~[a]~~ aggregate
6488 stop-loss ~~[contract]~~ insurance, are projected to be incurred by a small employer health plan
6489 using reasonable and accepted actuarial principles.

6490 (5) "Lasering":

6491 (a) means increasing or removing stop-loss coverage for a specific individual within an
6492 employer group; and

6493 (b) includes other practices that are prohibited by the commissioner by administrative
6494 rule that result in lowering the stop-loss premium for the employer by transferring the risk for
6495 an ~~[individual]~~ individual's claims back to the employer.

6496 (6) "Small employer" means an employer who, with respect to a calendar year and to a
6497 plan year:

6498 (a) employed an average of at least two employees but not more than 50 eligible
6499 employees on each business day during the preceding calendar year; and

6500 (b) employs at least two employees on the first day of the plan year.

6501 (7) "Specific attachment point" means the dollar amount ~~[in losses for eligible~~
6502 ~~expenses]~~ of covered claims attributable to a single individual covered by a small employer
6503 plan in a contract year beyond which the stop-loss insurer assumes ~~[all or part of]~~ the liability
6504 for losses incurred by the small employer plan, subject to limitations included in the contract.

6505 (8) "Stop-loss insurance" means insurance purchased by a small employer for which
6506 the stop-loss insurer assumes~~[, on a per-loss basis,]~~ all loss amounts of the small employer's
6507 plan in excess of a stated amount, subject to the policy limit.

6508 Section 64. Section **31A-43-301** is amended to read:

6509 **31A-43-301. Stop-loss insurance coverage standards.**

6510 (1) A small employer stop-loss insurance contract shall:

6511 (a) be issued to the small employer to provide insurance to the group health benefit
6512 plan, not the employees of the small employer;

6513 (b) use a standard application form developed by the commissioner by administrative
6514 rule;

6515 (c) have a contract term with guaranteed rates for at least 12 months, without
6516 adjustment, unless there is a change in the benefits provided under the small employer's health
6517 plan during the contract period;

6518 (d) include both a specific attachment point and an aggregate attachment point in a
6519 contract;

6520 (e) align stop-loss plan benefit limitations and exclusions with a small employer's
6521 health plan benefit limitations and exclusions, including any annual or lifetime limits in the
6522 employer's health plan;

6523 (f) have an annual specific attachment point that is at least \$10,000;

6524 (g) have an annual aggregate attachment point that may not be less than ~~[90%]~~ 85% of
6525 expected claims;

6526 (h) pay stop-loss claims:

6527 (i) incurred during the contract period; and

6528 (ii) ~~[submitted]~~ paid within 12 months after the expiration date of the contract; and

6529 (i) include provisions to cover incurred and unpaid claims if a small employer plan
6530 terminates.

6531 (2) A small employer stop-loss contract shall not:

6532 (a) include lasing; and

6533 (b) pay claims directly to an individual employee, member, or participant.

6534 Section 65. Section **31A-43-302** is amended to read:

6535 **31A-43-302. Stop-loss restrictions -- Filing requirements.**

6536 ~~[(1) A stop-loss insurer shall demonstrate to the commissioner that the rates associated~~
6537 ~~with specific and aggregate attachment points retained by a small employer group under the~~
6538 ~~insurer's stop-loss plan are actuarially sound.]~~

6539 ~~[(2)]~~ (1) A stop-loss insurer shall file the stop-loss insurance contract form and [rates]
6540 rate methodology with the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1
6541 before the stop-loss insurance contract may be issued or delivered in the state.

6542 ~~[(3)]~~ (2) A stop-loss insurer shall file with the commissioner, annually on or before
6543 April 1, in a form and manner required by the commissioner by administrative rule adopted by
6544 the commissioner:

6545 (a) an actuarial memorandum and certification which demonstrates that the insurer is in
6546 compliance with this chapter; and

6547 (b) the stop-loss insurer's stop-loss experience.

6548 ~~[(4) Each]~~ (3) An insurer shall maintain at its principal place of business:

6549 (a) a complete and detailed description of its rating practices and renewal underwriting
6550 practices, including information and documentation that demonstrate the rating methods and
6551 practices are:

6552 (i) based upon commonly accepted actuarial assumptions; and

6553 (ii) in accordance with sound actuarial principles; and

6554 (b) a copy of the ~~[actuarial certification]~~ annual filing required by Subsection ~~[(3)]~~ (2).
6555 Section 66. Section 31A-43-303 is amended to read:

6556 **31A-43-303. Stop-loss insurance disclosure.**

6557 A stop-loss insurance contract delivered, issued for delivery, or entered into shall
6558 include the disclosure exhibit required by the commissioner through administrative rule, which
6559 shall include at least the following information:

6560 (1) the complete costs for the stop-loss contract;

6561 (2) the date on which the insurance takes effect and terminates, including renewability
6562 provisions;

6563 (3) the aggregate attachment point and the specific attachment point;

6564 (4) ~~[any]~~ limitations on coverage;

6565 (5) an explanation of monthly accommodation and disclosure about any monthly
6566 accommodation features included in the stop-loss contract; ~~[and]~~

6567 (6) a description of terminal liability funding, including[:(a)] the cost of processing
 6568 claims before and after the termination of the contract; and
 6569 [(b)] (7) maximum claims liability to the employer.

6570 Section 67. Section **31A-43-304** is amended to read:

6571 **31A-43-304. Administrative rules.**

6572 The commissioner may adopt administrative rules in accordance with Title 63G,
 6573 Chapter 3, Utah Administrative Rulemaking Act, to:

6574 (1) implement this chapter;

6575 [~~(2)~~] ~~assure that differences in rates charged are reasonable and reflect objective~~
 6576 ~~differences in plan design;~~

6577 [~~(3)~~] (2) define lasering practices that are prohibited by this chapter;

6578 [~~(4)~~] (3) establish the form and manner of the actuarial certification and the annual
 6579 report on stop-loss experience required by Section [31A-43-302](#);

6580 [~~(5)~~] (4) establish the form and manner of the disclosure required by Section
 6581 [31A-43-303](#);

6582 [~~(6)~~] (5) assure the rates associated with the specific attachment points and aggregate
 6583 attachment points are actuarially sound and are not against the public interest; and

6584 [~~(7)~~] (6) assure that stop-loss contracts include provisions to cover incurred and unpaid
 6585 claims if a small employer plan terminates.

6586 Section 68. Section **53-13-103** is amended to read:

6587 **53-13-103. Law enforcement officer.**

6588 (1) (a) "Law enforcement officer" means a sworn and certified peace officer who is an
 6589 employee of a law enforcement agency that is part of or administered by the state or any of its
 6590 political subdivisions, and whose primary and principal duties consist of the prevention and
 6591 detection of crime and the enforcement of criminal statutes or ordinances of this state or any of
 6592 its political subdivisions.

6593 (b) "Law enforcement officer" specifically includes the following:

6594 (i) any sheriff or deputy sheriff, chief of police, police officer, or marshal of any
 6595 county, city, or town;

6596 (ii) the commissioner of public safety and any member of the Department of Public
 6597 Safety certified as a peace officer;

- 6598 (iii) all persons specified in Sections [23-20-1.5](#) and [79-4-501](#);
- 6599 (iv) any police officer employed by any college or university;
- 6600 (v) investigators for the Motor Vehicle Enforcement Division;
- 6601 (vi) investigators for the Department of Insurance, Fraud Division;
- 6602 [~~(vi)~~] (vii) special agents or investigators employed by the attorney general, district
- 6603 attorneys, and county attorneys;
- 6604 [~~(vii)~~] (viii) employees of the Department of Natural Resources designated as peace
- 6605 officers by law;
- 6606 [~~(viii)~~] (ix) school district police officers as designated by the board of education for
- 6607 the school district;
- 6608 [~~(ix)~~] (x) the executive director of the Department of Corrections and any correctional
- 6609 enforcement or investigative officer designated by the executive director and approved by the
- 6610 commissioner of public safety and certified by the division;
- 6611 [~~(x)~~] (xi) correctional enforcement, investigative, or adult probation and parole officers
- 6612 employed by the Department of Corrections serving on or before July 1, 1993;
- 6613 [~~(xi)~~] (xii) members of a law enforcement agency established by a private college or
- 6614 university provided that the college or university has been certified by the commissioner of
- 6615 public safety according to rules of the Department of Public Safety;
- 6616 [~~(xii)~~] (xiii) airport police officers of any airport owned or operated by the state or any
- 6617 of its political subdivisions; and
- 6618 [~~(xiii)~~] (xiv) transit police officers designated under Section [17B-2a-823](#).
- 6619 (2) Law enforcement officers may serve criminal process and arrest violators of any
- 6620 law of this state and have the right to require aid in executing their lawful duties.
- 6621 (3) (a) A law enforcement officer has statewide full-spectrum peace officer authority,
- 6622 but the authority extends to other counties, cities, or towns only when the officer is acting
- 6623 under Title 77, Chapter 9, Uniform Act on Fresh Pursuit, unless the law enforcement officer is
- 6624 employed by the state.
- 6625 (b) (i) A local law enforcement agency may limit the jurisdiction in which its law
- 6626 enforcement officers may exercise their peace officer authority to a certain geographic area.
- 6627 (ii) Notwithstanding Subsection (3)(b)(i), a law enforcement officer may exercise
- 6628 authority outside of the limited geographic area, pursuant to Title 77, Chapter 9, Uniform Act

6629 on Fresh Pursuit, if the officer is pursuing an offender for an offense that occurred within the
6630 limited geographic area.

6631 (c) The authority of law enforcement officers employed by the Department of
6632 Corrections is regulated by Title 64, Chapter 13, Department of Corrections - State Prison.

6633 (4) A law enforcement officer shall, prior to exercising peace officer authority:

6634 (a) (i) have satisfactorily completed the requirements of Section [53-6-205](#); or

6635 (ii) have met the waiver requirements in Section [53-6-206](#); and

6636 (b) have satisfactorily completed annual certified training of at least 40 hours per year

6637 as directed by the director of the division, with the advice and consent of the council.

6638 Section 69. **Repealer.**

6639 This bill repeals:

6640 Section [31A-30-110](#), **Individual enrollment cap.**

6641 Section [31A-30-111](#), **Limitations on high risk enrollees.**

6642 Section 70. **Effective date.**

6643 This bill takes effect on May 13, 2014, except that the amendments to Section

6644 [31A-3-304](#) (Effective 07/01/15) take effect on July 1, 2015.

6645 Section 71. **Coordinating H.B. 76 with H.B. 141 -- Superseding and substantive**
6646 **amendments.**

6647 If this H.B. 76 and H.B. 141, Health Reform Amendments, both pass and become law,

6648 it is the intent of the Legislature that the amendments to Sections [31A-23b-205](#) and

6649 [31A-23b-206](#) in H.B. 141, supersede the amendments to Sections [31A-23b-205](#) and

6650 [31A-23b-206](#) in this H.B. 76, when the Office of Legislative Research and General Counsel

6651 prepares the Utah Code database for publication.

6652 Section 72. **Revisor instructions.**

6653 The Legislature intends that the Office of Legislative Research and General Counsel, in

6654 preparing the Utah Code database for publication, replace the language in Subsections

6655 [31A-22-305](#)(10)(l) and [31A-22-305.3](#)(9)(l), from "this bill" with the bill's designated chapter

6656 and section number in the Laws of Utah.