

HEALTH REFORM AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill amends and enacts code sections related to health care insurance and the health care insurance market.

Highlighted Provisions:

This bill:

- ▶ amends definitions for the Insurance Code;
- ▶ effective January 1, 2018, merges the regulation of health insurance plans that are offered by managed care organizations into a managed care organization chapter of the Insurance Code;
- ▶ amends the duties of the Office of Consumer Health Services within the Governor's Office of Economic Development to require the office to wind down the small employer health insurance exchange known as Avenue H ~~H~~ → [~~by January 1, 2018~~] ← ~~H~~ ;
- ▶ removes health plan transparency reporting requirements for plans offered on the small employer health insurance exchange;
- ▶ repeals the defined contribution arrangements and the individual and small employer risk adjustment, which are part of the small employer health insurance exchange, effective July 1, 2019;
- ▶ reauthorizes the Health Reform Task Force for two years;
- ▶ establishes the duties of the task force; and
- ▶ makes technical amendments and conforming amendments.

H.B. 336



28 **Money Appropriated in this Bill:**

29 This bill appropriates for fiscal year 2017:

- 30 ▶ to Legislature - Senate as a one-time appropriation:
 - 31 • from the General Fund, One-time, \$20,000;
- 32 ▶ to Legislature - House of Representatives as a one-time appropriation:
 - 33 • from the General Fund, One-time, \$34,000.

34 **Other Special Clauses:**

35 This bill provides a special effective date.

36 **Utah Code Sections Affected:**

37 AMENDS:

- 38 **26-19-14**, as last amended by Laws of Utah 1995, Chapter 102
- 39 **31A-1-301**, as last amended by Laws of Utah 2016, Chapter 138
- 40 **31A-2-201.2**, as last amended by Laws of Utah 2015, Chapter 283
- 41 **31A-4-115**, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
- 42 **31A-8-101**, as last amended by Laws of Utah 2002, Chapter 308
- 43 **31A-8-103**, as last amended by Laws of Utah 2010, Chapter 324
- 44 **31A-21-106**, as last amended by Laws of Utah 2003, Chapter 252
- 45 **31A-22-610.1**, as last amended by Laws of Utah 2014, Chapter 353
- 46 **31A-22-610.5**, as last amended by Laws of Utah 2011, Chapter 297
- 47 **31A-22-613.5**, as last amended by Laws of Utah 2015, Chapters 257 and 283
- 48 **31A-22-618**, as last amended by Laws of Utah 2015, Chapter 367
- 49 **31A-22-618.5**, as last amended by Laws of Utah 2014, Chapters 290 and 300
- 50 **31A-22-627**, as last amended by Laws of Utah 2016, Chapter 295
- 51 **31A-22-628**, as enacted by Laws of Utah 2000, Chapter 37
- 52 **31A-22-635**, as last amended by Laws of Utah 2015, Chapter 283
- 53 **31A-22-642**, as enacted by Laws of Utah 2014, Chapter 379
- 54 **31A-23a-402**, as last amended by Laws of Utah 2015, Chapters 244 and 283
- 55 **31A-30-102**, as last amended by Laws of Utah 2015, Chapter 283
- 56 **31A-30-104**, as last amended by Laws of Utah 2014, Chapters 290 and 300
- 57 **31A-30-106.7**, as last amended by Laws of Utah 2014, Chapters 290 and 300
- 58 **31A-30-204**, as last amended by Laws of Utah 2015, Chapter 283

59 **31A-34-110**, as last amended by Laws of Utah 2001, Chapter 108
60 **49-20-407**, as last amended by Laws of Utah 2012, Chapter 127
61 **53-2a-1102**, as last amended by Laws of Utah 2015, Chapter 408
62 **58-16a-601**, as last amended by Laws of Utah 2014, Chapter 305
63 **63I-2-231**, as last amended by Laws of Utah 2016, Chapter 138
64 **63N-11-104**, as renumbered and amended by Laws of Utah 2015, Chapter 283

65 ENACTS:

66 **31A-45-101**, Utah Code Annotated 1953
67 **31A-45-102**, Utah Code Annotated 1953
68 **31A-45-103**, Utah Code Annotated 1953
69 **31A-45-201**, Utah Code Annotated 1953
70 **31A-45-301**, Utah Code Annotated 1953
71 **31A-45-302**, Utah Code Annotated 1953
72 **31A-45-402**, Utah Code Annotated 1953

73 RENUMBERS AND AMENDS:

74 **31A-22-618.6**, (Renumbered from 31A-8-402.3, as last amended by Laws of Utah
75 2014, Chapters 290, 300, and 425)
76 **31A-22-618.7**, (Renumbered from 31A-8-402.5, as last amended by Laws of Utah
77 2003, Chapter 252)
78 **31A-22-618.8**, (Renumbered from 31A-8-402.7, as last amended by Laws of Utah
79 2005, Chapter 78)
80 **31A-45-303**, (Renumbered from 31A-22-617, as last amended by Laws of Utah 2014,
81 Chapters 290 and 300)
82 **31A-45-304**, (Renumbered from 31A-22-617.1, as enacted by Laws of Utah 2005, First
83 Special Session, Chapter 3)
84 **31A-45-401**, (Renumbered from 31A-8-502, as enacted by Laws of Utah 2004, Chapter
85 178)
86 **31A-45-501**, (Renumbered from 31A-8-501, as last amended by Laws of Utah 2012,
87 Chapter 369)
88 REPEALS:
89 **31A-22-721**, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425

- 90 [31A-30-107](#), as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
- 91 [31A-30-107.1](#), as last amended by Laws of Utah 2003, Chapter 252
- 92 [31A-30-107.3](#), as last amended by Laws of Utah 2013, Chapter 341
- 93 [31A-30-116](#), as last amended by Laws of Utah 2016, Chapter 138
- 94 [63N-11-107](#), as renumbered and amended by Laws of Utah 2015, Chapter 283

95 **Uncodified Material Affected:**

96 ENACTS UNCODIFIED MATERIAL



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

99 Section 1. Section **26-19-14** is amended to read:

100 **26-19-14. Insurance policies not to deny or reduce benefits of persons eligible for**
101 **state medical assistance -- Exemptions.**

102 (1) A policy of accident or sickness insurance [~~issued or renewed after May 12, 1981,~~]
103 may not contain any provision denying or reducing benefits because services are rendered to an
104 insured or dependent who is eligible for or receiving medical assistance from the state.

105 (2) [~~After May 12, 1981, no~~] An association, corporation, or organization may not
106 deliver, issue for delivery, or renew any subscriber's contract which contains any provisions
107 denying or reducing benefits because services are rendered to a subscriber or dependent who is
108 eligible for or receiving medical assistance from the state.

109 (3) [~~After May 12, 1981, no~~] An association, corporation, business, or organization
110 authorized to do business in this state and which provides or pays for any health care benefits
111 may not deny or reduce benefits because services are rendered to a beneficiary who is eligible
112 for or receiving medical assistance from the state.

113 (4) Notwithstanding Subsection (1), (2), or (3), the Utah State Public Employees
114 Health Program, administered by the Utah State Retirement Board, is not required to reimburse
115 any agency of state government for custodial care which the agency provides, through its staff
116 or facilities, to members of the Utah State Public Employees Health Program.

117 [~~(5) This section is subject to the provisions of Subsection [31A-22-610.5\(3\)](#).]~~

118 Section 2. Section **31A-1-301** is amended to read:

119 **31A-1-301. Definitions.**

120 As used in this title, unless otherwise specified:

- 121 (1) (a) "Accident and health insurance" means insurance to provide protection against
122 economic losses resulting from:
- 123 (i) a medical condition including:
 - 124 (A) a medical care expense; or
 - 125 (B) the risk of disability;
 - 126 (ii) accident; or
 - 127 (iii) sickness.
- 128 (b) "Accident and health insurance":
- 129 (i) includes a contract with disability contingencies including:
 - 130 (A) an income replacement contract;
 - 131 (B) a health care contract;
 - 132 (C) an expense reimbursement contract;
 - 133 (D) a credit accident and health contract;
 - 134 (E) a continuing care contract; and
 - 135 (F) a long-term care contract; and
 - 136 (ii) may provide:
 - 137 (A) hospital coverage;
 - 138 (B) surgical coverage;
 - 139 (C) medical coverage;
 - 140 (D) loss of income coverage;
 - 141 (E) prescription drug coverage;
 - 142 (F) dental coverage; or
 - 143 (G) vision coverage.
 - 144 (c) "Accident and health insurance" does not include workers' compensation insurance.
- 145 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
146 63G, Chapter 3, Utah Administrative Rulemaking Act.
- 147 (3) "Administrator" means the same as that term is defined in Subsection [~~(166)~~] (170).
- 148 (4) "Adult" means an individual who has attained the age of at least 18 years.
- 149 (5) "Affiliate" means a person who controls, is controlled by, or is under common
150 control with, another person. A corporation is an affiliate of another corporation, regardless of
151 ownership, if substantially the same group of individuals manage the corporations.

- 152 (6) "Agency" means:
- 153 (a) a person other than an individual, including a sole proprietorship by which an
- 154 individual does business under an assumed name; and
- 155 (b) an insurance organization licensed or required to be licensed under Section
- 156 [31A-23a-301](#), [31A-25-207](#), or [31A-26-209](#).
- 157 (7) "Alien insurer" means an insurer domiciled outside the United States.
- 158 (8) "Amendment" means an endorsement to an insurance policy or certificate.
- 159 (9) "Annuity" means an agreement to make periodical payments for a period certain or
- 160 over the lifetime of one or more individuals if the making or continuance of all or some of the
- 161 series of the payments, or the amount of the payment, is dependent upon the continuance of
- 162 human life.
- 163 (10) "Application" means a document:
- 164 (a) (i) completed by an applicant to provide information about the risk to be insured;
- 165 and
- 166 (ii) that contains information that is used by the insurer to evaluate risk and decide
- 167 whether to:
- 168 (A) insure the risk under:
- 169 (I) the coverage as originally offered; or
- 170 (II) a modification of the coverage as originally offered; or
- 171 (B) decline to insure the risk; or
- 172 (b) used by the insurer to gather information from the applicant before issuance of an
- 173 annuity contract.
- 174 (11) "Articles" or "articles of incorporation" means:
- 175 (a) the original articles;
- 176 (b) a special law;
- 177 (c) a charter;
- 178 (d) an amendment;
- 179 (e) restated articles;
- 180 (f) articles of merger or consolidation;
- 181 (g) a trust instrument;
- 182 (h) another constitutive document for a trust or other entity that is not a corporation;

183 and

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

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

188 (13) "Binder" means the same as that term is defined in Section 31A-21-102.

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

191 (a) without individual underwriting or application; and

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

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

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

196 (a) that is open to the public;

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

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

199 (17) "Business entity" means:

200 (a) a corporation;

201 (b) an association;

202 (c) a partnership;

203 (d) a limited liability company;

204 (e) a limited liability partnership; or

205 (f) another legal entity.

206 (18) "Business of insurance" means the same as that term is defined in Subsection
207 [~~(89)~~] (91).

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

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

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

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

214 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
215 corporation's affairs, however designated.

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

218 (21) "Captive insurance company" means:

219 (a) an insurer:

220 (i) owned by another organization; and

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

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

224 (i) owned by the insureds; and

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

226 (A) a member organization;

227 (B) a group member; or

228 (C) an affiliate of:

229 (I) a member organization; or

230 (II) a group member.

231 (22) "Casualty insurance" means liability insurance.

232 (23) "Certificate" means evidence of insurance given to:

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

234 (b) a third party.

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

236 (25) "Claim," unless the context otherwise requires, means a request or demand on an
237 insurer for payment of a benefit according to the terms of an insurance policy.

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

241 (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
242 commissioner.

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

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

246 (i) provides board and lodging;

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

248 (A) a personal service;

249 (B) a nursing service;

250 (C) a medical service; or

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

252 (iii) provides the coverage described in this Subsection (28)(a) under an agreement

253 effective:

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

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

256 (b) Insurance is continuing care insurance regardless of whether or not the board and

257 lodging are provided at the same location as a service described in Subsection (28)(a)(ii).

258 (29) (a) "Control," "controlling," "controlled," or "under common control" means the

259 direct or indirect possession of the power to direct or cause the direction of the management

260 and policies of a person. This control may be:

261 (i) by contract;

262 (ii) by common management;

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

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

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

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

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

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

274 (31) "Controlling person" means a person that directly or indirectly has the power to
275 direct or cause to be directed, the management, control, or activities of a reinsurance

276 intermediary.

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

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

280 (i) a corporation doing business:

281 (A) as:

282 (I) an insurance producer;

283 (II) a surplus lines producer;

284 (III) a limited line producer;

285 (IV) a consultant;

286 (V) a managing general agent;

287 (VI) a reinsurance intermediary;

288 (VII) a third party administrator; or

289 (VIII) an adjuster; and

290 (B) under:

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

292 Reinsurance Intermediaries;

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

294 (III) Chapter 26, Insurance Adjusters; or

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

296 Holding Companies.

297 ~~(b)~~ (b) "Mutual" or "mutual corporation" means a mutual insurance corporation.

298 ~~(c)~~ (c) "Stock corporation" means a stock insurance corporation.

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

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

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

304 demonstration waiver obtained subject to Section [26-18-3](#);

305 (ii) the Children's Health Insurance Program under Section [26-40-106](#); or

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

307 No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No.
308 109-415.

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

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

314 (b) "Credit insurance" includes:

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

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

326 (38) "Creditor" means a person, including an insured, having a claim, whether:

- 327 (a) matured;
- 328 (b) unmatured;
- 329 (c) liquidated;
- 330 (d) unliquidated;
- 331 (e) secured;
- 332 (f) unsecured;
- 333 (g) absolute;
- 334 (h) fixed; or
- 335 (i) contingent.

336 (39) "Credit property insurance" means insurance:

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

- 338 (b) that protects the property until the debt is paid.
- 339 (40) "Credit unemployment insurance" means insurance:
- 340 (a) offered in connection with an extension of credit; and
- 341 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
- 342 (i) specific loan; or
- 343 (ii) credit transaction.
- 344 (41) (a) "Crop insurance" means insurance providing protection against damage to
- 345 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,
- 346 disease, or other yield-reducing conditions or perils that is:
- 347 (i) provided by the private insurance market; or
- 348 (ii) subsidized by the Federal Crop Insurance Corporation.
- 349 (b) "Crop insurance" includes multiperil crop insurance.
- 350 (42) (a) "Customer service representative" means a person that provides an insurance
- 351 service and insurance product information:
- 352 (i) for the customer service representative's:
- 353 (A) producer;
- 354 (B) surplus lines producer; or
- 355 (C) consultant employer; and
- 356 (ii) to the customer service representative's employer's:
- 357 (A) customer;
- 358 (B) client; or
- 359 (C) organization.
- 360 (b) A customer service representative may only operate within the scope of authority of
- 361 the customer service representative's producer, surplus lines producer, or consultant employer.
- 362 (43) "Deadline" means a final date or time:
- 363 (a) imposed by:
- 364 (i) statute;
- 365 (ii) rule; or
- 366 (iii) order; and
- 367 (b) by which a required filing or payment must be received by the department.
- 368 (44) "Deemer clause" means a provision under this title under which upon the

369 occurrence of a condition precedent, the commissioner is considered to have taken a specific
370 action. If the statute so provides, a condition precedent may be the commissioner's failure to
371 take a specific action.

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

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

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

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

379 (a) perform the duties of:

380 (i) that individual's occupation; or

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

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

384 (i) eating;

385 (ii) toileting;

386 (iii) transferring;

387 (iv) bathing; or

388 (v) dressing.

389 (49) "Disability income insurance" means the same as that term is defined in
390 Subsection [~~(80)~~] (82).

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

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

393 (a) is incorporated;

394 (b) is organized; or

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

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

397 (i) an employee who:

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

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

- 400 (ii) a person described in Subsection (52)(b).
- 401 (b) "Eligible employee" includes:
- 402 (i) an owner who:
- 403 (A) works on a full-time basis; and
- 404 (B) has a normal work week of 30 or more hours; and
- 405 (ii) if the individual is included under a health benefit plan of a small employer:
- 406 (A) a sole proprietor;
- 407 (B) a partner in a partnership; or
- 408 (C) an independent contractor.
- 409 (c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):
- 410 (i) an individual who works on a temporary or substitute basis for a small employer;
- 411 (ii) an employer's spouse who does not meet the requirements of Subsection (52)(a)(i);
- 412 or
- 413 (iii) a dependent of an employer who does not meet the requirements of Subsection
- 414 (52)(a)(i).
- 415 (53) "Employee" means:
- 416 (a) an individual employed by an employer; and
- 417 (b) an owner who meets the requirements of Subsection (52)(b)(i).
- 418 (54) "Employee benefits" means one or more benefits or services provided to:
- 419 (a) an employee; or
- 420 (b) a dependent of an employee.
- 421 (55) (a) "Employee welfare fund" means a fund:
- 422 (i) established or maintained, whether directly or through a trustee, by:
- 423 (A) one or more employers;
- 424 (B) one or more labor organizations; or
- 425 (C) a combination of employers and labor organizations; and
- 426 (ii) that provides employee benefits paid or contracted to be paid, other than income
- 427 from investments of the fund:
- 428 (A) by or on behalf of an employer doing business in this state; or
- 429 (B) for the benefit of a person employed in this state.
- 430 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax

431 revenues.

432 (56) "Endorsement" means a written agreement attached to a policy or certificate to
433 modify the policy or certificate coverage.

434 (57) (a) "Enrollee" means:

435 (i) a policyholder;

436 (ii) a certificate holder;

437 (iii) a subscriber; or

438 (iv) a covered individual:

439 (A) who has entered into a contract with an organization for health care; or

440 (B) on whose behalf an arrangement for health care has been made.

441 (b) "Enrollee" includes an insured.

442 [~~(57)~~] (58) "Enrollment date," with respect to a health benefit plan, means:

443 (a) the first day of coverage; or

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

445 [~~(58)~~] (59) "Enterprise risk" means an activity, circumstance, event, or series of events
446 involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a
447 material adverse effect upon the financial condition or liquidity of the insurer or its insurance
448 holding company system as a whole, including anything that would cause:

449 (a) the insurer's risk-based capital to fall into an action or control level as set forth in
450 Sections [31A-17-601](#) through [31A-17-613](#); or

451 (b) the insurer to be in hazardous financial condition set forth in Section [31A-27a-101](#).

452 [~~(59)~~] (60) (a) "Escrow" means:

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

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

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

459 (ii) a settlement or closing involving:

460 (A) a mobile home;

461 (B) a grazing right;

- 462 (C) a water right; or
- 463 (D) other personal property authorized by the commissioner.
- 464 (b) "Escrow" does not include:
- 465 (i) the following notarial acts performed by a notary within the state:
- 466 (A) an acknowledgment;
- 467 (B) a copy certification;
- 468 (C) jurat; and
- 469 (D) an oath or affirmation;
- 470 (ii) the receipt or delivery of a document; or
- 471 (iii) the receipt of money for delivery to the escrow agent.
- 472 ~~[(60)]~~ (61) "Escrow agent" means an agency title insurance producer meeting the
- 473 requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an
- 474 individual title insurance producer licensed with an escrow subline of authority.
- 475 ~~[(61)]~~ (62) (a) "Excludes" is not exhaustive and does not mean that another thing is not
- 476 also excluded.
- 477 (b) The items listed in a list using the term "excludes" are representative examples for
- 478 use in interpretation of this title.
- 479 ~~[(62)]~~ (63) "Exclusion" means for the purposes of accident and health insurance that an
- 480 insurer does not provide insurance coverage, for whatever reason, for one of the following:
- 481 (a) a specific physical condition;
- 482 (b) a specific medical procedure;
- 483 (c) a specific disease or disorder; or
- 484 (d) a specific prescription drug or class of prescription drugs.
- 485 ~~[(63)]~~ (64) "Expense reimbursement insurance" means insurance:
- 486 (a) written to provide a payment for an expense relating to hospital confinement
- 487 resulting from illness or injury; and
- 488 (b) written:
- 489 (i) as a daily limit for a specific number of days in a hospital; and
- 490 (ii) to have a one or two day waiting period following a hospitalization.
- 491 ~~[(64)]~~ (65) "Fidelity insurance" means insurance guaranteeing the fidelity of a person
- 492 holding a position of public or private trust.

493 [~~(65)~~] (66) (a) "Filed" means that a filing is:

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

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

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

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

500 (B) rule.

501 (b) "Filed" does not include a filing that is rejected by the department because it is not
502 submitted in accordance with Subsection [~~(65)~~] (66)(a).

503 [~~(66)~~] (67) "Filing," when used as a noun, means an item required to be filed with the
504 department including:

505 (a) a policy;

506 (b) a rate;

507 (c) a form;

508 (d) a document;

509 (e) a plan;

510 (f) a manual;

511 (g) an application;

512 (h) a report;

513 (i) a certificate;

514 (j) an endorsement;

515 (k) an actuarial certification;

516 (l) a licensee annual statement;

517 (m) a licensee renewal application;

518 (n) an advertisement;

519 (o) a binder; or

520 (p) an outline of coverage.

521 [~~(67)~~] (68) "First party insurance" means an insurance policy or contract in which the
522 insurer agrees to pay a claim submitted to it by the insured for the insured's losses.

523 [~~(68)~~] (69) "Foreign insurer" means an insurer domiciled outside of this state, including

524 an alien insurer.

525 [~~(69)~~] (70) (a) "Form" means one of the following prepared for general use:

526 (i) a policy;

527 (ii) a certificate;

528 (iii) an application;

529 (iv) an outline of coverage; or

530 (v) an endorsement.

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

532 case.

533 [~~(70)~~] (71) "Franchise insurance" means an individual insurance policy provided
534 through a mass marketing arrangement involving a defined class of persons related in some
535 way other than through the purchase of insurance.

536 [~~(71)~~] (72) "General lines of authority" include:

537 (a) the general lines of insurance in Subsection [~~(72)~~] (73);

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

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

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

541 (iii) title marketing representative only;

542 (c) surplus lines;

543 (d) workers' compensation; and

544 (e) another line of insurance that the commissioner considers necessary to recognize in
545 the public interest.

546 [~~(72)~~] (73) "General lines of insurance" include:

547 (a) accident and health;

548 (b) casualty;

549 (c) life;

550 (d) personal lines;

551 (e) property; and

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

553 [~~(73)~~] (74) "Group health plan" means an employee welfare benefit plan to the extent
554 that the plan provides medical care:

- 555 (a) (i) to an employee; or
- 556 (ii) to a dependent of an employee; and
- 557 (b) (i) directly;
- 558 (ii) through insurance reimbursement; or
- 559 (iii) through another method.

560 ~~[(74)]~~ (75) (a) "Group insurance policy" means a policy covering a group of persons
 561 that is issued:

- 562 (i) to a policyholder on behalf of the group; and
- 563 (ii) for the benefit of a member of the group who is selected under a procedure defined
- 564 in:

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

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

569 ~~[(75)]~~ (76) "Guaranteed automobile protection insurance" means insurance offered in
 570 connection with an extension of credit that pays the difference in amount between the
 571 insurance settlement and the balance of the loan if the insured automobile is a total loss.

572 ~~[(76)(a) Except as provided in Subsection (76)(b), "health benefit plan" means a policy~~
 573 ~~or certificate that:]~~

- 574 ~~[(i) provides health care insurance;]~~
- 575 ~~[(ii) provides major medical expense insurance; or]~~
- 576 ~~[(iii) is offered as a substitute for hospital or medical expense insurance, such as:]~~
- 577 ~~[(A) a hospital confinement indemnity; or]~~
- 578 ~~[(B) a limited benefit plan.]~~
- 579 ~~[(b) "Health benefit plan" does not include a policy or certificate that:]~~
- 580 ~~[(i) provides benefits solely for:]~~
- 581 ~~[(A) accident;]~~
- 582 ~~[(B) dental;]~~
- 583 ~~[(C) income replacement;]~~
- 584 ~~[(D) long-term care;]~~
- 585 ~~[(E) a Medicare supplement;]~~

586 ~~[(F) a specified disease;]~~
587 ~~[(G) vision; or]~~
588 ~~[(H) a short-term limited duration; or]~~
589 ~~[(ii) is offered and marketed as supplemental health insurance.]~~
590 (77) (a) "Health benefit plan" means, except as provided in Subsection (77)(b), a
591 policy, contract, certificate, or agreement offered or issued by a health carrier to provide,
592 deliver, arrange for, pay for, or reimburse any of the costs of health care.
593 (b) "Health benefit plan" does not include:
594 (i) coverage only for accident or disability income insurance, or any combination
595 thereof;
596 (ii) coverage issued as a supplement to liability insurance;
597 (iii) liability insurance, including general liability insurance and automobile liability
598 insurance;
599 (iv) workers' compensation or similar insurance;
600 (v) automobile medical payment insurance;
601 (vi) credit-only insurance;
602 (vii) coverage for on-site medical clinics;
603 (viii) other similar insurance coverage, specified in federal regulations issued pursuant
604 to Pub. L. No. 104-191, under which benefits for health care services are secondary or
605 incidental to other insurance benefits;
606 (ix) the following benefits if they are provided under a separate policy, certificate, or
607 contract of insurance or are otherwise not an integral part of the plan:
608 (A) limited scope dental or vision benefits;
609 (B) benefits for long-term care, nursing home care, home health care,
610 community-based care, or any combination thereof; or
611 (C) other similar, limited benefits specified in federal regulations issued pursuant to
612 Pub. L. No. 104-191;
613 (x) the following benefits if the benefits are provided under a separate policy,
614 certificate, or contract of insurance, there is no coordination between the provision of benefits
615 and any exclusion of benefits under any health plan, and the benefits are paid with respect to an
616 event without regard to whether benefits are provided under any health plan:

- 617 (A) coverage only for specified disease or illness; or
- 618 (B) hospital indemnity or other fixed indemnity insurance; and
- 619 (xi) the following if offered as a separate policy, certificate, or contract of insurance:
- 620 (A) Medicare supplemental health insurance as defined under of the Social Security
- 621 Act, 42 U.S.C. Sec. 1395ss(g)(1);
- 622 (B) coverage supplemental to the coverage provided under Unites States Code, Title
- 623 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services
- 624 (CHAMPUS); or
- 625 (C) similar supplemental coverage provided to coverage under a group health insurance
- 626 plan.
- 627 ~~[(77)]~~ (78) "Health care" means any of the following intended for use in the diagnosis,
- 628 treatment, mitigation, or prevention of a human ailment or impairment:
- 629 (a) a professional service;
- 630 (b) a personal service;
- 631 (c) a facility;
- 632 (d) equipment;
- 633 (e) a device;
- 634 (f) supplies; or
- 635 (g) medicine.
- 636 ~~[(78)]~~ (79) (a) "Health care insurance" or "health insurance" means insurance
- 637 providing:
- 638 (i) a health care benefit; or
- 639 (ii) payment of an incurred health care expense.
- 640 (b) "Health care insurance" or "health insurance" does not include accident and health
- 641 insurance providing a benefit for:
- 642 (i) replacement of income;
- 643 (ii) short-term accident;
- 644 (iii) fixed indemnity;
- 645 (iv) credit accident and health;
- 646 (v) supplements to liability;
- 647 (vi) workers' compensation;

- 648 (vii) automobile medical payment;
- 649 (viii) no-fault automobile;
- 650 (ix) equivalent self-insurance; or
- 651 (x) a type of accident and health insurance coverage that is a part of or attached to
- 652 another type of policy.

653 (80) "Health care provider" means the same as that term is defined in Section
654 78B-3-403.

655 [~~(79)~~] (81) "Health Insurance Portability and Accountability Act" means the Health
656 Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as
657 amended.

658 [~~(80)~~] (82) "Income replacement insurance" or "disability income insurance" means
659 insurance written to provide payments to replace income lost from accident or sickness.

660 [~~(81)~~] (83) "Indemnity" means the payment of an amount to offset all or part of an
661 insured loss.

662 [~~(82)~~] (84) "Independent adjuster" means an insurance adjuster required to be licensed
663 under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

664 [~~(83)~~] (85) "Independently procured insurance" means insurance procured under
665 Section 31A-15-104.

666 [~~(84)~~] (86) "Individual" means a natural person.

667 [~~(85)~~] (87) "Inland marine insurance" includes insurance covering:

- 668 (a) property in transit on or over land;
- 669 (b) property in transit over water by means other than boat or ship;
- 670 (c) bailee liability;
- 671 (d) fixed transportation property such as bridges, electric transmission systems, radio
- 672 and television transmission towers and tunnels; and
- 673 (e) personal and commercial property floaters.

674 [~~(86)~~] (88) "Insolvency" means that:

- 675 (a) an insurer is unable to pay its debts or meet its obligations as the debts and
- 676 obligations mature;
- 677 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
- 678 RBC under Subsection 31A-17-601(8)(c); or

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

680 [~~(87)~~] (89) (a) "Insurance" means:

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

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

685 (b) "Insurance" includes:

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

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

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

692 [~~(88)~~] (90) "Insurance adjuster" means a person who directs or conducts the
693 investigation, negotiation, or settlement of a claim under an insurance policy other than life
694 insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance
695 policy.

696 [~~(89)~~] (91) "Insurance business" or "business of insurance" includes:

697 (a) providing health care insurance by an organization that is or is required to be
698 licensed under this title;

699 (b) providing a benefit to an employee in the event of a contingency not within the
700 control of the employee, in which the employee is entitled to the benefit as a right, which
701 benefit may be provided either:

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

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

704 (c) providing an annuity:

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

706 (ii) except an annuity provided by a person specified in Subsections [31A-22-1305\(2\)](#)

707 and (3);

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

709 [~~(117)~~] (120);

- 710 (e) providing another person with insurance;
- 711 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,
- 712 or surety, a contract or policy of title insurance;
- 713 (g) transacting or proposing to transact any phase of title insurance, including:
- 714 (i) solicitation;
- 715 (ii) negotiation preliminary to execution;
- 716 (iii) execution of a contract of title insurance;
- 717 (iv) insuring; and
- 718 (v) transacting matters subsequent to the execution of the contract and arising out of
- 719 the contract, including reinsurance;
- 720 (h) transacting or proposing a life settlement; and
- 721 (i) doing, or proposing to do, any business in substance equivalent to Subsections
- 722 ~~[(89)]~~ (91)(a) through (h) in a manner designed to evade this title.
- 723 ~~[(90)]~~ (92) "Insurance consultant" or "consultant" means a person who:
- 724 (a) advises another person about insurance needs and coverages;
- 725 (b) is compensated by the person advised on a basis not directly related to the insurance
- 726 placed; and
- 727 (c) except as provided in Section 31A-23a-501, is not compensated directly or
- 728 indirectly by an insurer or producer for advice given.
- 729 ~~[(91)]~~ (93) "Insurance holding company system" means a group of two or more
- 730 affiliated persons, at least one of whom is an insurer.
- 731 ~~[(92)]~~ (94) (a) "Insurance producer" or "producer" means a person licensed or required
- 732 to be licensed under the laws of this state to sell, solicit, or negotiate insurance.
- 733 (b) (i) "Producer for the insurer" means a producer who is compensated directly or
- 734 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that
- 735 insurer.
- 736 (ii) "Producer for the insurer" may be referred to as an "agent."
- 737 (c) (i) "Producer for the insured" means a producer who:
- 738 (A) is compensated directly and only by an insurance customer or an insured; and
- 739 (B) receives no compensation directly or indirectly from an insurer for selling,
- 740 soliciting, or negotiating an insurance product of that insurer to an insurance customer or

741 insured.

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

743 ~~[(93)]~~ (95) (a) "Insured" means a person to whom or for whose benefit an insurer

744 makes a promise in an insurance policy and includes:

745 (i) a policyholder;

746 (ii) a subscriber;

747 (iii) a member; and

748 (iv) a beneficiary.

749 (b) The definition in Subsection ~~[(93)]~~ (95)(a):

750 (i) applies only to this title; ~~[and]~~

751 (ii) does not define the meaning of ~~[this word]~~ "insured" as used in an insurance policy

752 or certificate~~[-];~~ and

753 (iii) includes an enrollee.

754 ~~[(94)]~~ (96) (a) "Insurer" means a person doing an insurance business as a principal

755 including:

756 (i) a fraternal benefit society;

757 (ii) an issuer of a gift annuity other than an annuity specified in Subsections

758 [31A-22-1305](#)(2) and (3);

759 (iii) a motor club;

760 (iv) an employee welfare plan; ~~[and]~~

761 (v) a person purporting or intending to do an insurance business as a principal on that

762 person's own account~~[-];~~ and

763 (vi) a health maintenance organization.

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

765 entity is engaged in an activity described in Section [31A-12-107](#).

766 ~~[(95)]~~ (97) "Interinsurance exchange" means the same as that term is defined in

767 Subsection ~~[(148)]~~ (152).

768 ~~[(96)]~~ (98) "Involuntary unemployment insurance" means insurance:

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

770 (b) that provides indemnity if the debtor is involuntarily unemployed for payments

771 coming due on a:

- 772 (i) specific loan; or
- 773 (ii) credit transaction.

774 ~~[(97)]~~ (99) (a) "Large employer," in connection with a health benefit plan, means an
775 employer who, with respect to a calendar year and to a plan year:

776 (i) employed an average of at least 51 employees on business days during the preceding
777 calendar year; and

778 (ii) employs at least one employee on the first day of the plan year.

779 (b) The number of employees shall be determined using the method set forth in 26
780 U.S.C. Sec. 4980H(c)(2).

781 ~~[(98)]~~ (100) "Late enrollee," with respect to an employer health benefit plan, means an
782 individual whose enrollment is a late enrollment.

783 ~~[(99)]~~ (101) "Late enrollment," with respect to an employer health benefit plan, means
784 enrollment of an individual other than:

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

787 (b) through special enrollment.

788 ~~[(100)]~~ (102) (a) Except for a retainer contract or legal assistance described in Section
789 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a
790 specified legal expense.

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

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

795 ~~[(101)]~~ (103) (a) "Liability insurance" means insurance against liability:

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

798 (A) ~~[Subsection (111) for]~~ medical malpractice insurance;

799 (B) ~~[Subsection (139) for]~~ professional liability insurance; and

800 (C) ~~[Subsection (175) for]~~ workers' compensation insurance;

801 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the
802 insured who is injured, irrespective of legal liability of the insured, when issued with or

803 supplemental to insurance against legal liability for the death, injury, or disability of a human
804 being, exclusive of the coverages under:

- 805 (A) [~~Subsection (111) for~~] medical malpractice insurance;
- 806 (B) [~~Subsection (139) for~~] professional liability insurance; and
- 807 (C) [~~Subsection (175) for~~] workers' compensation insurance;
- 808 (iii) for loss or damage to property resulting from an accident to or explosion of a
809 boiler, pipe, pressure container, machinery, or apparatus;
- 810 (iv) for loss or damage to property caused by:
- 811 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
- 812 (B) water entering through a leak or opening in a building; or
- 813 (v) for other loss or damage properly the subject of insurance not within another kind
814 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.

815 (b) "Liability insurance" includes:

- 816 (i) vehicle liability insurance;
- 817 (ii) residential dwelling liability insurance; and
- 818 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
819 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
820 elevator, boiler, machinery, or apparatus.

821 [~~(102)~~] (104) (a) "License" means authorization issued by the commissioner to engage
822 in an activity that is part of or related to the insurance business.

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

824 [~~(103)~~] (105) (a) "Life insurance" means:

- 825 (i) insurance on a human life; and
- 826 (ii) insurance pertaining to or connected with human life.
- 827 (b) The business of life insurance includes:
- 828 (i) granting a death benefit;
- 829 (ii) granting an annuity benefit;
- 830 (iii) granting an endowment benefit;
- 831 (iv) granting an additional benefit in the event of death by accident;
- 832 (v) granting an additional benefit to safeguard the policy against lapse; and
- 833 (vi) providing an optional method of settlement of proceeds.

- 834 [~~(104)~~] (106) "Limited license" means a license that:
- 835 (a) is issued for a specific product of insurance; and
- 836 (b) limits an individual or agency to transact only for that product or insurance.
- 837 [~~(105)~~] (107) "Limited line credit insurance" includes the following forms of
- 838 insurance:
- 839 (a) credit life;
- 840 (b) credit accident and health;
- 841 (c) credit property;
- 842 (d) credit unemployment;
- 843 (e) involuntary unemployment;
- 844 (f) mortgage life;
- 845 (g) mortgage guaranty;
- 846 (h) mortgage accident and health;
- 847 (i) guaranteed automobile protection; and
- 848 (j) another form of insurance offered in connection with an extension of credit that:
- 849 (i) is limited to partially or wholly extinguishing the credit obligation; and
- 850 (ii) the commissioner determines by rule should be designated as a form of limited line
- 851 credit insurance.
- 852 [~~(106)~~] (108) "Limited line credit insurance producer" means a person who sells,
- 853 solicits, or negotiates one or more forms of limited line credit insurance coverage to an
- 854 individual through a master, corporate, group, or individual policy.
- 855 [~~(107)~~] (109) "Limited line insurance" includes:
- 856 (a) bail bond;
- 857 (b) limited line credit insurance;
- 858 (c) legal expense insurance;
- 859 (d) motor club insurance;
- 860 (e) car rental related insurance;
- 861 (f) travel insurance;
- 862 (g) crop insurance;
- 863 (h) self-service storage insurance;
- 864 (i) guaranteed asset protection waiver;

865 (j) portable electronics insurance; and
866 (k) another form of limited insurance that the commissioner determines by rule should
867 be designated a form of limited line insurance.

868 [~~(108)~~] (110) "Limited lines authority" includes the lines of insurance listed in
869 Subsection [~~(107)~~] (109).

870 [~~(109)~~] (111) "Limited lines producer" means a person who sells, solicits, or negotiates
871 limited lines insurance.

872 [~~(110)~~] (112) (a) "Long-term care insurance" means an insurance policy or rider
873 advertised, marketed, offered, or designated to provide coverage:

874 (i) in a setting other than an acute care unit of a hospital;
875 (ii) for not less than 12 consecutive months for a covered person on the basis of:

876 (A) expenses incurred;

877 (B) indemnity;

878 (C) prepayment; or

879 (D) another method;

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

881 (A) diagnostic;

882 (B) preventative;

883 (C) therapeutic;

884 (D) rehabilitative;

885 (E) maintenance; or

886 (F) personal care; and

887 (iv) that may be issued by:

888 (A) an insurer;

889 (B) a fraternal benefit society;

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

891 (II) a medical service corporation;

892 (D) a prepaid health plan;

893 (E) a health maintenance organization; or

894 (F) an entity similar to the entities described in Subsections [~~(110)~~] (112)(a)(iv)(A)

895 through (E) to the extent that the entity is otherwise authorized to issue life or health care

- 896 insurance.
- 897 (b) "Long-term care insurance" includes:
- 898 (i) any of the following that provide directly or supplement long-term care insurance:
- 899 (A) a group or individual annuity or rider; or
- 900 (B) a life insurance policy or rider;
- 901 (ii) a policy or rider that provides for payment of benefits on the basis of:
- 902 (A) cognitive impairment; or
- 903 (B) functional capacity; or
- 904 (iii) a qualified long-term care insurance contract.
- 905 (c) "Long-term care insurance" does not include:
- 906 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
- 907 (ii) basic hospital expense coverage;
- 908 (iii) basic medical/surgical expense coverage;
- 909 (iv) hospital confinement indemnity coverage;
- 910 (v) major medical expense coverage;
- 911 (vi) income replacement or related asset-protection coverage;
- 912 (vii) accident only coverage;
- 913 (viii) coverage for a specified:
- 914 (A) disease; or
- 915 (B) accident;
- 916 (ix) limited benefit health coverage; or
- 917 (x) a life insurance policy that accelerates the death benefit to provide the option of a
- 918 lump sum payment:
- 919 (A) if the following are not conditioned on the receipt of long-term care:
- 920 (I) benefits; or
- 921 (II) eligibility; and
- 922 (B) the coverage is for one or more the following qualifying events:
- 923 (I) terminal illness;
- 924 (II) medical conditions requiring extraordinary medical intervention; or
- 925 (III) permanent institutional confinement.
- 926 (113) "Managed care organization" means a person:

927 (a) licensed as a health maintenance organization under Chapter 8, Health Maintenance
 928 Organizations and Limited Health Plans; or

929 (b) (i) licensed under:

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

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

932 (C) Chapter 14, Foreign Insurers; and

933 (ii) that requires an enrollee to use, or offers incentives, including financial incentives,
 934 for an enrollee to use, network providers.

935 [~~(111)~~] (114) "Medical malpractice insurance" means insurance against legal liability
 936 incident to the practice and provision of a medical service other than the practice and provision
 937 of a dental service.

938 [~~(112)~~] (115) "Member" means a person having membership rights in an insurance
 939 corporation.

940 [~~(113)~~] (116) "Minimum capital" or "minimum required capital" means the capital that
 941 must be constantly maintained by a stock insurance corporation as required by statute.

942 [~~(114)~~] (117) "Mortgage accident and health insurance" means insurance offered in
 943 connection with an extension of credit that provides indemnity for payments coming due on a
 944 mortgage while the debtor has a disability.

945 [~~(115)~~] (118) "Mortgage guaranty insurance" means surety insurance under which a
 946 mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

947 [~~(116)~~] (119) "Mortgage life insurance" means insurance on the life of a debtor in
 948 connection with an extension of credit that pays if the debtor dies.

949 [~~(117)~~] (120) "Motor club" means a person:

950 (a) licensed under:

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

952 (ii) Chapter 11, Motor Clubs; or

953 (iii) Chapter 14, Foreign Insurers; and

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

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

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

- 958 (iii) (A) trip reimbursement;
- 959 (B) towing services;
- 960 (C) emergency road services;
- 961 (D) stolen automobile services;
- 962 (E) a combination of the services listed in Subsections [~~(117)~~] (120)(b)(iii)(A) through
- 963 (D); or

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

965 [~~(118)~~] (121) "Mutual" means a mutual insurance corporation.

966 [~~(119)~~] (122) "Network plan" means health care insurance:

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

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

971 (123) "Network provider" means a health care provider who has an agreement with a
972 managed care organization to provide health care services to an enrollee with an expectation of
973 receiving payment, other than coinsurance, copayments, or deductibles, directly from the
974 managed care organization.

975 [~~(120)~~] (124) "Nonparticipating" means a plan of insurance under which the insured is
976 not entitled to receive a dividend representing a share of the surplus of the insurer.

977 [~~(121)~~] (125) "Ocean marine insurance" means insurance against loss of or damage to:

978 (a) ships or hulls of ships;

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

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

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

987 [~~(122)~~] (126) "Order" means an order of the commissioner.

988 [~~(123)~~] (127) "Outline of coverage" means a summary that explains an accident and

989 health insurance policy.

990 ~~[(124)]~~ (128) "Participating" means a plan of insurance under which the insured is
 991 entitled to receive a dividend representing a share of the surplus of the insurer.

992 ~~[(125)]~~ (129) "Participation," as used in a health benefit plan, means a requirement
 993 relating to the minimum percentage of eligible employees that must be enrolled in relation to
 994 the total number of eligible employees of an employer reduced by each eligible employee who
 995 voluntarily declines coverage under the plan because the employee:

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

997 (b) receives:

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

1000 (ii) another government health benefit.

1001 ~~[(126)]~~ (130) "Person" includes:

1002 (a) an individual;

1003 (b) a partnership;

1004 (c) a corporation;

1005 (d) an incorporated or unincorporated association;

1006 (e) a joint stock company;

1007 (f) a trust;

1008 (g) a limited liability company;

1009 (h) a reciprocal;

1010 (i) a syndicate; or

1011 (j) another similar entity or combination of entities acting in concert.

1012 ~~[(127)]~~ (131) "Personal lines insurance" means property and casualty insurance
 1013 coverage sold for primarily noncommercial purposes to:

1014 (a) an individual; or

1015 (b) a family.

1016 ~~[(128)]~~ (132) "Plan sponsor" ~~[is-as]~~ means the same as that term is defined in 29
 1017 U.S.C. Sec. 1002(16)(B).

1018 ~~[(129)]~~ (133) "Plan year" means:

1019 (a) the year that is designated as the plan year in:

- 1020 (i) the plan document of a group health plan; or
- 1021 (ii) a summary plan description of a group health plan;
- 1022 (b) if the plan document or summary plan description does not designate a plan year or
- 1023 there is no plan document or summary plan description:
- 1024 (i) the year used to determine deductibles or limits;
- 1025 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;
- 1026 or
- 1027 (iii) the employer's taxable year if:
- 1028 (A) the plan does not impose deductibles or limits on a yearly basis; and
- 1029 (B) (I) the plan is not insured; or
- 1030 (II) the insurance policy is not renewed on an annual basis; or
- 1031 (c) in a case not described in Subsection [~~(129)~~] (133)(a) or (b), the calendar year.
- 1032 [~~(130)~~] (134) (a) "Policy" means a document, including an attached endorsement or
- 1033 application that:
- 1034 (i) purports to be an enforceable contract; and
- 1035 (ii) memorializes in writing some or all of the terms of an insurance contract.
- 1036 (b) "Policy" includes a service contract issued by:
- 1037 (i) a motor club under Chapter 11, Motor Clubs;
- 1038 (ii) a service contract provided under Chapter 6a, Service Contracts; and
- 1039 (iii) a corporation licensed under:
- 1040 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
- 1041 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
- 1042 (c) "Policy" does not include:
- 1043 (i) a certificate under a group insurance contract; or
- 1044 (ii) a document that does not purport to have legal effect.
- 1045 [~~(131)~~] (135) "Policyholder" means a person who controls a policy, binder, or oral
- 1046 contract by ownership, premium payment, or otherwise.
- 1047 [~~(132)~~] (136) "Policy illustration" means a presentation or depiction that includes
- 1048 nonguaranteed elements of a policy of life insurance over a period of years.
- 1049 [~~(133)~~] (137) "Policy summary" means a synopsis describing the elements of a life
- 1050 insurance policy.

1051 [~~(134)~~] (138) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L.
1052 No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152,
1053 and related federal regulations and guidance.

1054 [~~(135)~~] (139) "Preexisting condition," with respect to a health benefit plan:

1055 (a) means a condition that was present before the effective date of coverage, whether or
1056 not medical advice, diagnosis, care, or treatment was recommended or received before that day,
1057 and

1058 (b) does not include a condition indicated by genetic information unless an actual
1059 diagnosis of the condition by a physician has been made.

1060 [~~(136)~~] (140) (a) "Premium" means the monetary consideration for an insurance policy.

1061 (b) "Premium" includes, however designated:

1062 (i) an assessment;

1063 (ii) a membership fee;

1064 (iii) a required contribution; or

1065 (iv) monetary consideration.

1066 (c) (i) "Premium" does not include consideration paid to a third party administrator for
1067 the third party administrator's services.

1068 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for
1069 insurance on the risks administered by the third party administrator.

1070 [~~(137)~~] (141) "Principal officers" for a corporation means the officers designated under
1071 Subsection [31A-5-203\(3\)](#).

1072 [~~(138)~~] (142) "Proceeding" includes an action or special statutory proceeding.

1073 [~~(139)~~] (143) "Professional liability insurance" means insurance against legal liability
1074 incident to the practice of a profession and provision of a professional service.

1075 [~~(140)~~] (144) (a) Except as provided in Subsection [~~(140)~~] (144)(b), "property
1076 insurance" means insurance against loss or damage to real or personal property of every kind
1077 and any interest in that property:

1078 (i) from all hazards or causes; and

1079 (ii) against loss consequential upon the loss or damage including vehicle
1080 comprehensive and vehicle physical damage coverages.

1081 (b) "Property insurance" does not include:

1082 (i) inland marine insurance; and
1083 (ii) ocean marine insurance.

1084 [~~(141)~~] (145) "Qualified long-term care insurance contract" or "federally tax qualified
1085 long-term care insurance contract" means:

1086 (a) an individual or group insurance contract that meets the requirements of Section
1087 7702B(b), Internal Revenue Code; or

1088 (b) the portion of a life insurance contract that provides long-term care insurance:

1089 (i) (A) by rider; or

1090 (B) as a part of the contract; and

1091 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue
1092 Code.

1093 [~~(142)~~] (146) "Qualified United States financial institution" means an institution that:

1094 (a) is:

1095 (i) organized under the laws of the United States or any state; or

1096 (ii) in the case of a United States office of a foreign banking organization, licensed
1097 under the laws of the United States or any state;

1098 (b) is regulated, supervised, and examined by a United States federal or state authority
1099 having regulatory authority over a bank or trust company; and

1100 (c) meets the standards of financial condition and standing that are considered
1101 necessary and appropriate to regulate the quality of a financial institution whose letters of credit
1102 will be acceptable to the commissioner as determined by:

1103 (i) the commissioner by rule; or

1104 (ii) the Securities Valuation Office of the National Association of Insurance

1105 Commissioners.

1106 [~~(143)~~] (147) (a) "Rate" means:

1107 (i) the cost of a given unit of insurance; or

1108 (ii) for property or casualty insurance, that cost of insurance per exposure unit either
1109 expressed as:

1110 (A) a single number; or

1111 (B) a pure premium rate, adjusted before the application of individual risk variations
1112 based on loss or expense considerations to account for the treatment of:

- 1113 (I) expenses;
- 1114 (II) profit; and
- 1115 (III) individual insurer variation in loss experience.
- 1116 (b) "Rate" does not include a minimum premium.
- 1117 ~~[(144)]~~ (148) (a) Except as provided in Subsection ~~[(144)]~~ (148)(b), "rate service
- 1118 organization" means a person who assists an insurer in rate making or filing by:
- 1119 (i) collecting, compiling, and furnishing loss or expense statistics;
- 1120 (ii) recommending, making, or filing rates or supplementary rate information; or
- 1121 (iii) advising about rate questions, except as an attorney giving legal advice.
- 1122 (b) "Rate service organization" does not mean:
- 1123 (i) an employee of an insurer;
- 1124 (ii) a single insurer or group of insurers under common control;
- 1125 (iii) a joint underwriting group; or
- 1126 (iv) an individual serving as an actuarial or legal consultant.
- 1127 ~~[(145)]~~ (149) "Rating manual" means any of the following used to determine initial and
- 1128 renewal policy premiums:
- 1129 (a) a manual of rates;
- 1130 (b) a classification;
- 1131 (c) a rate-related underwriting rule; and
- 1132 (d) a rating formula that describes steps, policies, and procedures for determining
- 1133 initial and renewal policy premiums.
- 1134 ~~[(146)]~~ (150) (a) "Rebate" means a licensee paying, allowing, giving, or offering to
- 1135 pay, allow, or give, directly or indirectly:
- 1136 (i) a refund of premium or portion of premium;
- 1137 (ii) a refund of commission or portion of commission;
- 1138 (iii) a refund of all or a portion of a consultant fee; or
- 1139 (iv) providing services or other benefits not specified in an insurance or annuity
- 1140 contract.
- 1141 (b) "Rebate" does not include:
- 1142 (i) a refund due to termination or changes in coverage;
- 1143 (ii) a refund due to overcharges made in error by the licensee; or

- 1144 (iii) savings or wellness benefits as provided in the contract by the licensee.
1145 [~~(147)~~] (151) "Received by the department" means:
1146 (a) the date delivered to and stamped received by the department, if delivered in
1147 person;
1148 (b) the post mark date, if delivered by mail;
1149 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
1150 (d) the received date recorded on an item delivered, if delivered by:
1151 (i) facsimile;
1152 (ii) email; or
1153 (iii) another electronic method; or
1154 (e) a date specified in:
1155 (i) a statute;
1156 (ii) a rule; or
1157 (iii) an order.

1158 [~~(148)~~] (152) "Reciprocal" or "interinsurance exchange" means an unincorporated
1159 association of persons:

- 1160 (a) operating through an attorney-in-fact common to all of the persons; and
1161 (b) exchanging insurance contracts with one another that provide insurance coverage
1162 on each other.

1163 [~~(149)~~] (153) "Reinsurance" means an insurance transaction where an insurer, for
1164 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1165 reinsurance transactions, this title sometimes refers to:

- 1166 (a) the insurer transferring the risk as the "ceding insurer"; and
1167 (b) the insurer assuming the risk as the:
1168 (i) "assuming insurer"; or
1169 (ii) "assuming reinsurer."

1170 [~~(150)~~] (154) "Reinsurer" means a person licensed in this state as an insurer with the
1171 authority to assume reinsurance.

1172 [~~(151)~~] (155) "Residential dwelling liability insurance" means insurance against
1173 liability resulting from or incident to the ownership, maintenance, or use of a residential
1174 dwelling that is a detached single family residence or multifamily residence up to four units.

1175 [~~(152)~~] (156) (a) "Retrocession" means reinsurance with another insurer of a liability
1176 assumed under a reinsurance contract.

1177 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a
1178 liability assumed under a reinsurance contract.

1179 [~~(153)~~] (157) "Rider" means an endorsement to:

1180 (a) an insurance policy; or

1181 (b) an insurance certificate.

1182 [~~(154)~~] (158) "Secondary medical condition" means a complication related to an
1183 exclusion from coverage in accident and health insurance.

1184 [~~(155)~~] (159) (a) "Security" means a:

1185 (i) note;

1186 (ii) stock;

1187 (iii) bond;

1188 (iv) debenture;

1189 (v) evidence of indebtedness;

1190 (vi) certificate of interest or participation in a profit-sharing agreement;

1191 (vii) collateral-trust certificate;

1192 (viii) preorganization certificate or subscription;

1193 (ix) transferable share;

1194 (x) investment contract;

1195 (xi) voting trust certificate;

1196 (xii) certificate of deposit for a security;

1197 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
1198 payments out of production under such a title or lease;

1199 (xiv) commodity contract or commodity option;

1200 (xv) certificate of interest or participation in, temporary or interim certificate for,
1201 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
1202 in Subsections [~~(155)~~] (159)(a)(i) through (xiv); or

1203 (xvi) another interest or instrument commonly known as a security.

1204 (b) "Security" does not include:

1205 (i) any of the following under which an insurance company promises to pay money in a

1206 specific lump sum or periodically for life or some other specified period:

1207 (A) insurance;

1208 (B) an endowment policy; or

1209 (C) an annuity contract; or

1210 (ii) a burial certificate or burial contract.

1211 [~~(156)~~] (160) "Securityholder" means a specified person who owns a security of a
1212 person, including:

1213 (a) common stock;

1214 (b) preferred stock;

1215 (c) debt obligations; and

1216 (d) any other security convertible into or evidencing the right of any of the items listed
1217 in this Subsection [~~(156)~~] (160).

1218 [~~(157)~~] (161) (a) "Self-insurance" means an arrangement under which a person
1219 provides for spreading its own risks by a systematic plan.

1220 (b) Except as provided in this Subsection [~~(157)~~] (161), "self-insurance" does not
1221 include an arrangement under which a number of persons spread their risks among themselves.

1222 (c) "Self-insurance" includes:

1223 (i) an arrangement by which a governmental entity undertakes to indemnify an
1224 employee for liability arising out of the employee's employment; and

1225 (ii) an arrangement by which a person with a managed program of self-insurance and
1226 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
1227 employees for liability or risk that is related to the relationship or employment.

1228 (d) "Self-insurance" does not include an arrangement with an independent contractor.

1229 [~~(158)~~] (162) "Sell" means to exchange a contract of insurance:

1230 (a) by any means;

1231 (b) for money or its equivalent; and

1232 (c) on behalf of an insurance company.

1233 [~~(159)~~] (163) "Short-term care insurance" means an insurance policy or rider
1234 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care
1235 insurance, but that provides coverage for less than 12 consecutive months for each covered
1236 person.

1237 ~~[(160)]~~ (164) "Significant break in coverage" means a period of 63 consecutive days
1238 during each of which an individual does not have creditable coverage.

1239 ~~[(161)]~~ (165) (a) "Small employer" means, in connection with a health benefit plan and
1240 with respect to a calendar year and to a plan year, an employer who:

1241 (i) employed at least one employee but not more than 50 employees on business days
1242 during the preceding calendar year; and

1243 (ii) employs at least one employee on the first day of the plan year.

1244 (b) The number of employees shall:

1245 (i) be determined using the method set forth in 26 U.S.C. Sec. 4980H(c)(2); and

1246 (ii) include an owner described in Subsection (52)(b)(i).

1247 (c) "Small employer" does not include a sole proprietor that does not employ at least
1248 one employee.

1249 ~~[(162)]~~ (166) "Special enrollment period," in connection with a health benefit plan, has
1250 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance
1251 Portability and Accountability Act.

1252 ~~[(163)]~~ (167) (a) "Subsidiary" of a person means an affiliate controlled by that person
1253 either directly or indirectly through one or more affiliates or intermediaries.

1254 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
1255 shares are owned by that person either alone or with its affiliates, except for the minimum
1256 number of shares the law of the subsidiary's domicile requires to be owned by directors or
1257 others.

1258 ~~[(164)]~~ (168) Subject to Subsection ~~[(87)]~~ (89)(b), "surety insurance" includes:

1259 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or
1260 perform the principal's obligations to a creditor or other obligee;

1261 (b) bail bond insurance; and

1262 (c) fidelity insurance.

1263 ~~[(165)]~~ (169) (a) "Surplus" means the excess of assets over the sum of paid-in capital
1264 and liabilities.

1265 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is
1266 designated by the insurer or organization as permanent.

1267 (ii) Sections [31A-5-211](#), [31A-7-201](#), [31A-8-209](#), [31A-9-209](#), and [31A-14-205](#) require

1268 that insurers or organizations doing business in this state maintain specified minimum levels of
1269 permanent surplus.

1270 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the
1271 same as the minimum required capital requirement that applies to stock insurers.

1272 (c) "Excess surplus" means:

1273 (i) for a life insurer, accident and health insurer, health organization, or property and
1274 casualty insurer as defined in Section 31A-17-601, the lesser of:

1275 (A) that amount of an insurer's or health organization's total adjusted capital that
1276 exceeds the product of:

1277 (I) 2.5; and

1278 (II) the sum of the insurer's or health organization's minimum capital or permanent
1279 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

1280 (B) that amount of an insurer's or health organization's total adjusted capital that
1281 exceeds the product of:

1282 (I) 3.0; and

1283 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

1284 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer
1285 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

1286 (A) 1.5; and

1287 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

1288 [~~(166)~~] (170) "Third party administrator" or "administrator" means a person who
1289 collects charges or premiums from, or who, for consideration, adjusts or settles claims of
1290 residents of the state in connection with insurance coverage, annuities, or service insurance
1291 coverage, except:

1292 (a) a union on behalf of its members;

1293 (b) a person administering a:

1294 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1295 1974;

1296 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or

1297 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;

1298 (c) an employer on behalf of the employer's employees or the employees of one or

- 1299 more of the subsidiary or affiliated corporations of the employer;
- 1300 (d) an insurer licensed under the following, but only for a line of insurance for which
- 1301 the insurer holds a license in this state:
- 1302 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
- 1303 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;
- 1304 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
- 1305 (iv) Chapter 9, Insurance Fraternal; or
- 1306 (v) Chapter 14, Foreign Insurers;
- 1307 (e) a person:
- 1308 (i) licensed or exempt from licensing under:
- 1309 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
- 1310 Reinsurance Intermediaries; or
- 1311 (B) Chapter 26, Insurance Adjusters; and
- 1312 (ii) whose activities are limited to those authorized under the license the person holds
- 1313 or for which the person is exempt; or
- 1314 (f) an institution, bank, or financial institution:
- 1315 (i) that is:
- 1316 (A) an institution whose deposits and accounts are to any extent insured by a federal
- 1317 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
- 1318 Credit Union Administration; or
- 1319 (B) a bank or other financial institution that is subject to supervision or examination by
- 1320 a federal or state banking authority; and
- 1321 (ii) that does not adjust claims without a third party administrator license.
- 1322 ~~[(167)]~~ (171) "Title insurance" means the insuring, guaranteeing, or indemnifying of an
- 1323 owner of real or personal property or the holder of liens or encumbrances on that property, or
- 1324 others interested in the property against loss or damage suffered by reason of liens or
- 1325 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
- 1326 or unenforceability of any liens or encumbrances on the property.
- 1327 ~~[(168)]~~ (172) "Total adjusted capital" means the sum of an insurer's or health
- 1328 organization's statutory capital and surplus as determined in accordance with:
- 1329 (a) the statutory accounting applicable to the annual financial statements required to be

1330 filed under Section [31A-4-113](#); and

1331 (b) another item provided by the RBC instructions, as RBC instructions is defined in
1332 Section [31A-17-601](#).

1333 [~~(169)~~] [\(173\)](#) (a) "Trustee" means "director" when referring to the board of directors of
1334 a corporation.

1335 (b) "Trustee," when used in reference to an employee welfare fund, means an
1336 individual, firm, association, organization, joint stock company, or corporation, whether acting
1337 individually or jointly and whether designated by that name or any other, that is charged with
1338 or has the overall management of an employee welfare fund.

1339 [~~(170)~~] [\(174\)](#) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted
1340 insurer" means an insurer:

1341 (i) not holding a valid certificate of authority to do an insurance business in this state;

1342 or

1343 (ii) transacting business not authorized by a valid certificate.

1344 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1345 (i) holding a valid certificate of authority to do an insurance business in this state; and

1346 (ii) transacting business as authorized by a valid certificate.

1347 [~~(171)~~] [\(175\)](#) "Underwrite" means the authority to accept or reject risk on behalf of the
1348 insurer.

1349 [~~(172)~~] [\(176\)](#) "Vehicle liability insurance" means insurance against liability resulting
1350 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a
1351 vehicle comprehensive or vehicle physical damage coverage under Subsection [~~(140)~~] [\(144\)](#).

1352 [~~(173)~~] [\(177\)](#) "Voting security" means a security with voting rights, and includes a
1353 security convertible into a security with a voting right associated with the security.

1354 [~~(174)~~] [\(178\)](#) "Waiting period" for a health benefit plan means the period that must
1355 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of
1356 the health benefit plan, can become effective.

1357 [~~(175)~~] [\(179\)](#) "Workers' compensation insurance" means:

1358 (a) insurance for indemnification of an employer against liability for compensation
1359 based on:

1360 (i) a compensable accidental injury; and

- 1361 (ii) occupational disease disability;
- 1362 (b) employer's liability insurance incidental to workers' compensation insurance and
- 1363 written in connection with workers' compensation insurance; and
- 1364 (c) insurance assuring to a person entitled to workers' compensation benefits the
- 1365 compensation provided by law.

1366 Section 3. Section **31A-2-201.2** is amended to read:

1367 **31A-2-201.2. Evaluation of health insurance market.**

1368 (1) Each year the commissioner shall:

- 1369 (a) conduct an evaluation of the state's health insurance market;
- 1370 (b) report the findings of the evaluation to the Health and Human Services Interim
- 1371 Committee before October 1 of each year; and
- 1372 (c) publish the findings of the evaluation on the department website.

1373 (2) The evaluation required by this section shall:

1374 (a) analyze the effectiveness of the insurance regulations and statutes in promoting a

1375 healthy, competitive health insurance market that meets the needs of the state, and includes an

1376 analysis of:

- 1377 (i) the availability and marketing of individual and group products;
- 1378 (ii) rate changes;
- 1379 (iii) coverage and demographic changes;
- 1380 (iv) benefit trends;
- 1381 (v) market share changes; and
- 1382 (vi) accessibility;

1383 (b) assess complaint ratios and trends within the health insurance market, which

1384 assessment shall include complaint data from the Office of Consumer Health Assistance within

1385 the department;

1386 (c) contain recommendations for action to improve the overall effectiveness of the

1387 health insurance market, administrative rules, and statutes; and

1388 (d) include claims loss ratio data for each health insurance company doing business in

1389 the state.

1390 ~~[(3) When preparing the evaluation required by this section, the commissioner shall~~

1391 ~~include a report of:]~~

1392 ~~[(a) the types of health benefit plans sold in the Health Insurance Exchange created in~~
 1393 ~~Section [63N-11-104](#);~~]

1394 ~~[(b) the number of insurers participating in the defined contribution arrangement health~~
 1395 ~~benefit plans in the Health Insurance Exchange; and]~~

1396 ~~[(c) the number of employers and covered lives in the defined contribution~~
 1397 ~~arrangement market in the Health Insurance Exchange.]~~

1398 ~~[(4)]~~ (3) When preparing the evaluation and report required by this section, the
 1399 commissioner may seek the input of insurers, employers, insured persons, providers, and others
 1400 with an interest in the health insurance market.

1401 ~~[(5)]~~ (4) The commissioner may adopt administrative rules for the purpose of
 1402 collecting the data required by this section, taking into account the business confidentiality of
 1403 the insurers.

1404 ~~[(6)]~~ (5) Records submitted to the commissioner under this section shall be maintained
 1405 by the commissioner as protected records under Title 63G, Chapter 2, Government Records
 1406 Access and Management Act.

1407 Section 4. Section **31A-4-115** is amended to read:

1408 **31A-4-115. Plan of orderly withdrawal.**

1409 (1) (a) When an insurer intends to withdraw from writing a line of insurance in this
 1410 state or to reduce its total annual premium volume by 75% or more, the insurer shall file with
 1411 the commissioner a plan of orderly withdrawal.

1412 (b) For purposes of this section, a discontinuance of a health benefit plan [~~pursuant to~~
 1413 ~~one of the following provisions]~~ is a withdrawal from a line of insurance~~[-(i)]~~ under
 1414 ~~[Subsection [31A-30-107\(3\)\(c\)](#); or (ii) Subsection [31A-30-107.1\(3\)\(c\)](#)]~~ Subsections
 1415 [31A-22-618.6\(5\)](#) or [31A-22-618.7\(3\)](#).

1416 (2) An insurer's plan of orderly withdrawal shall:

1417 (a) indicate the date the insurer intends to begin and complete its withdrawal plan; and

1418 (b) include provisions for:

1419 (i) meeting the insurer's contractual obligations;

1420 (ii) providing services to its Utah policyholders and claimants;

1421 (iii) meeting applicable statutory obligations; and

1422 (iv) the payment of a withdrawal fee of \$50,000 to the department if the insurer's line

1423 of business is not assumed or placed with another insurer approved by the commissioner.

1424 (3) The commissioner shall approve a plan of orderly withdrawal if the plan of orderly
1425 withdrawal adequately demonstrates that the insurer will:

1426 (a) protect the interests of the people of the state;

1427 (b) meet the insurer's contractual obligations;

1428 (c) provide service to the insurer's Utah policyholders and claimants; and

1429 (d) meet applicable statutory obligations.

1430 (4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for
1431 orderly withdrawal.

1432 (5) The commissioner may require an insurer to increase the deposit maintained in
1433 accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in
1434 the name of the commissioner upon finding, after an adjudicative proceeding that:

1435 (a) there is reasonable cause to conclude that the interests of the people of the state are
1436 best served by such action; and

1437 (b) the insurer:

1438 (i) has filed a plan of orderly withdrawal; or

1439 (ii) intends to:

1440 (A) withdraw from writing a line of insurance in this state; or

1441 (B) reduce the insurer's total annual premium volume by 75% or more.

1442 (6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:

1443 (a) withdraws from writing insurance in this state without receiving the commissioner's
1444 approval of a plan of orderly withdrawal; or

1445 (b) reduces its total annual premium volume by 75% or more in any year without
1446 receiving the commissioner's approval of a plan of orderly withdrawal.

1447 (7) An insurer that withdraws from writing all lines of insurance in this state may not
1448 resume writing insurance in this state for five years unless the commissioner finds that the
1449 prohibition should be waived because the waiver is:

1450 (a) in the public interest to promote competition; or

1451 (b) to resolve inequity in the marketplace.

1452 (8) The commissioner shall adopt rules necessary to implement this section.

1453 Section 5. Section 31A-8-101 is amended to read:

1454 **31A-8-101. Definitions.**

1455 For purposes of this chapter:

1456 (1) "Basic health care services" means:

1457 (a) emergency care;

1458 (b) inpatient hospital and physician care;

1459 (c) outpatient medical services; and

1460 (d) out-of-area coverage.

1461 [~~(2) "Director of health" means:~~]

1462 [~~(a) the executive director of the Department of Health; or]~~

1463 [~~(b) the authorized representative of the executive director of the Department of~~

1464 Health.]

1465 [~~(3) "Enrollee" means an individual:]~~

1466 [~~(a) who has entered into a contract with an organization for health care; or]~~

1467 [~~(b) in whose behalf an arrangement for health care has been made.]~~

1468 [~~(4) "Health care" is as defined in Section [31A-1-301](#).]~~

1469 [~~(5)~~ (2) "Health maintenance organization" means any person:

1470 (a) other than:

1471 (i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance

1472 Corporations; or

1473 (ii) an individual who contracts to render professional or personal services that the

1474 individual directly performs; and

1475 (b) that:

1476 (i) furnishes at a minimum, either directly or through arrangements with others, basic

1477 health care services to an enrollee in return for prepaid periodic payments agreed to in amount

1478 prior to the time during which the health care may be furnished; and

1479 (ii) is obligated to the enrollee to arrange for or to directly provide available and

1480 accessible health care.

1481 [~~(6)~~ (3) (a) "Limited health plan" means, except as limited under Subsection [~~(6)~~

1482 (3)(b), [~~any~~] a person who furnishes dental or vision services, either directly or through

1483 arrangements with others[~~, services~~]:

1484 [~~(i) of:~~]

1485 ~~[(A) dentists;]~~
1486 ~~[(B) optometrists;]~~
1487 ~~[(C) physical therapists;]~~
1488 ~~[(D) podiatrists;]~~
1489 ~~[(E) psychologists;]~~
1490 ~~[(F) physicians;]~~
1491 ~~[(G) chiropractic physicians;]~~
1492 ~~[(H) naturopathic physicians;]~~
1493 ~~[(I) osteopathic physicians;]~~
1494 ~~[(J) social workers;]~~
1495 ~~[(K) family counselors;]~~
1496 ~~[(L) other health care providers; or]~~
1497 ~~[(M) reasonable combinations of the services described in this Subsection (6)(a)(i);]~~
1498 ~~[(ii)] (i) to an enrollee;~~
1499 ~~[(iii)] (ii) in return for prepaid periodic payments agreed to in amount prior to the time~~
1500 during which the services may be furnished; and
1501 ~~[(iv)] (iii) for which the person is obligated to the enrollee to arrange for or directly~~
1502 provide the available and accessible services described in this Subsection ~~[(6)] (3)(a).~~
1503 (b) "Limited health plan" does not include:
1504 (i) a health maintenance organization;
1505 (ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance
1506 Corporations; or
1507 (iii) an individual who contracts to render professional or personal services that the
1508 individual performs.
1509 ~~[(7)] (4) (a) "Nonprofit organization" or "nonprofit corporation" means an organization~~
1510 no part of the income of which is distributable to its members, trustees, or officers, or a
1511 nonprofit cooperative association, except in a manner allowed under Section [31A-8-406](#).
1512 (b) "Nonprofit health maintenance organization" and "nonprofit limited health plan"
1513 are used when referring specifically to one of the types of organizations with "nonprofit" status.
1514 ~~[(8)] (5) "Organization" means a health maintenance organization and limited health~~
1515 plan, unless used in the context of:

1516 ~~[(b)]~~ (a) "organization expenses," which is described in Section 31A-8-208.

1517 ~~[(a)]~~ (b) "organization permit," which is described in Sections 31A-8-204 and

1518 31A-8-206; or

1519 ~~[(9)]~~ "Participating provider" means a provider as defined in Subsection (10) who,

1520 ~~under a contract with the health maintenance organization, agrees to provide health care~~

1521 ~~services to enrollees with an expectation of receiving payment, directly or indirectly, from the~~

1522 ~~health maintenance organization, other than copayment.]~~

1523 ~~[(10)]~~ "Provider" means any person who:

1524 ~~[(a)]~~ furnishes health care directly to the enrollee; and]

1525 ~~[(b)]~~ is licensed or otherwise authorized to furnish the health care in this state.]

1526 ~~[(H)]~~ (6) "Uncovered expenditures" means the costs of health care services that are

1527 covered by an organization for which an enrollee is liable in the event of the organization's

1528 insolvency.

1529 ~~[(12)]~~ (7) "Unusual or infrequently used health services" means those health services

1530 that are projected to involve fewer than 10% of the organization's enrollees' encounters with

1531 providers, measured on an annual basis over the organization's entire enrollment.

1532 Section 6. Section 31A-8-103 is amended to read:

1533 **31A-8-103. Applicability to other provisions of law.**

1534 (1) (a) Except for exemptions specifically granted under this title, an organization is

1535 subject to regulation under all of the provisions of this title.

1536 (b) Notwithstanding any provision of this title, an organization licensed under this

1537 chapter:

1538 (i) is wholly exempt from:

1539 (A) Chapter 7, Nonprofit Health Service Insurance Corporations;

1540 (B) Chapter 9, Insurance Fraternal;

1541 (C) Chapter 10, Annuities;

1542 (D) Chapter 11, Motor Clubs;

1543 (E) Chapter 12, State Risk Management Fund;

1544 ~~[(F)]~~ Chapter 13, Employee Welfare Funds and Plans;]

1545 ~~[(G)]~~ (F) Chapter 19a, Utah Rate Regulation Act; and

1546 ~~[(H)]~~ (G) Chapter 28, Part 1, Utah Life and Health Insurance Guaranty [~~Associations~~]

1547 Association Act; and

1548 (ii) is not subject to:

1549 (A) Chapter 3, Department Funding, Fees, and Taxes, except for Part 1, Funding the

1550 Insurance Department;

1551 (B) Section 31A-4-107;

1552 (C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for

1553 provisions specifically made applicable by this chapter;

1554 (D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by

1555 this chapter;

1556 (E) Chapter 17, Determination of Financial Condition, except:

1557 (I) Part 2, Qualified Assets, and Part 6, Risk-Based Capital; or

1558 (II) as made applicable by the commissioner by rule consistent with this chapter;

1559 (F) Chapter 18, Investments, except as made applicable by the commissioner by rule

1560 consistent with this chapter; and

1561 (G) Chapter 22, Contracts in Specific Lines, except for Part 6, Accident and Health

1562 Insurance, Part 7, Group Accident and Health Insurance, and Part 12, Reinsurance.

1563 (2) The commissioner may by rule waive other specific provisions of this title that the

1564 commissioner considers inapplicable to [~~health maintenance organizations or~~] limited health

1565 plans, upon a finding that the waiver will not endanger the interests of:

1566 (a) enrollees;

1567 (b) investors; or

1568 (c) the public.

1569 (3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16,

1570 Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as

1571 specifically made applicable by:

1572 (a) this chapter;

1573 (b) a provision referenced under this chapter; or

1574 (c) a rule adopted by the commissioner to deal with corporate law issues of health

1575 maintenance organizations that are not settled under this chapter.

1576 (4) (a) Whenever in this chapter, Chapter 5, Domestic Stock and Mutual Insurance

1577 Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization, the

1578 application is:

1579 (i) of those provisions that apply to a mutual corporation if the organization is
1580 nonprofit; and

1581 (ii) of those that apply to a stock corporation if the organization is for profit.

1582 (b) When Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter
1583 14, Foreign Insurers, is made applicable to an organization under this chapter, "mutual" means
1584 nonprofit organization.

1585 (5) Solicitation of enrollees by an organization is not a violation of any provision of
1586 law relating to solicitation or advertising by health professionals if that solicitation is made in
1587 accordance with:

1588 (a) this chapter; and

1589 (b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1590 Reinsurance Intermediaries.

1591 (6) This title does not prohibit any health maintenance organization from meeting the
1592 requirements of any federal law that enables the health maintenance organization to:

1593 (a) receive federal funds; or

1594 (b) obtain or maintain federal qualification status.

1595 (7) Except as provided in [~~Section 31A-8-501~~] Chapter 45, Managed Care
1596 Organizations, an organization is exempt from statutes in this title or department rules that
1597 restrict or limit the organization's freedom of choice in contracting with or selecting health care
1598 providers, including Section 31A-22-618.

1599 (8) An organization is exempt from the assessment or payment of premium taxes
1600 imposed by Sections 59-9-101 through 59-9-104.

1601 Section 7. Section 31A-21-106 is amended to read:

1602 **31A-21-106. Incorporation by reference.**

1603 (1) (a) Except as provided in Subsection (1)(b), an insurance policy may not contain
1604 any agreement or incorporate any provision not fully set forth in the policy or in an application
1605 or other document attached to and made a part of the policy at the time of its delivery, unless
1606 the policy, application, or agreement accurately reflects the terms of the incorporated
1607 agreement, provision, or attached document.

1608 (b) (i) A policy may by reference incorporate rate schedules and classifications of risks

1609 and short-rate tables filed with the commissioner.

1610 (ii) By rule or order, the commissioner may authorize incorporation by reference of
1611 provisions for:

1612 (A) administrative arrangements;

1613 (B) premium schedules; and

1614 (C) payment procedures for complex contracts.

1615 (c) (i) A policy of title insurance insuring the mortgage or deed of trust of an
1616 institutional lender may, if requested by an institutional lender, incorporate by reference
1617 generally applicable policy terms that are contained in a specifically identified policy that has
1618 been filed with the commissioner.

1619 (ii) As used in Subsection (1)(c)(i), "institutional lender" means a person that regularly
1620 engages in the business of making loans secured by real estate.

1621 (d) A policy may incorporate by reference the following by citing in the policy:

1622 (i) a federal law or regulation;

1623 (ii) a state law or rule; or

1624 (iii) a public directive of a federal or state agency.

1625 (2) A purported modification of a contract during the term of the policy may not affect
1626 the obligations of a party to the contract:

1627 (a) unless the modification is:

1628 (i) in writing; and

1629 (ii) agreed to by the party against whose interest the modification operates; and

1630 (b) except:

1631 (i) as provided in:

1632 (A) Subsection (3) or (4);

1633 (B) Subsection [~~31A-8-402.3~~] [31A-22-618.6\(9\)](#); or

1634 [~~(C) Subsection 31A-22-721(10); or~~]

1635 [~~(D)~~] (C) Subsection [~~31A-30-107(8)~~] [31A-22-618.7\(4\)](#); or

1636 (ii) as otherwise mandated by law.

1637 (3) Subsection (2) does not prevent a change in coverage under group contracts
1638 resulting from:

1639 (a) provisions of an employer eligibility rule;

- 1640 (b) the terms of a collective bargaining agreement; or
- 1641 (c) provisions in federal Employee Retirement Income Security Act plan documents.
- 1642 (4) Subsection (2) does not prevent a premium increase at any renewal date that is
- 1643 applicable uniformly to all comparable persons.

1644 Section 8. Section **31A-22-610.1** is amended to read:

1645 **31A-22-610.1. Indemnity benefit for adoption or infertility treatments.**

1646 (1) (a) (i) If an insured has coverage for maternity benefits on the date of an adoptive
1647 placement, the insured's policy shall provide an adoption indemnity benefit payable to the
1648 insured, if a child is placed for adoption with the insured within 90 days of the child's birth. If
1649 more than one child from the same birth is placed for adoption with the insured, only one
1650 adoption indemnity benefit is required.

1651 (ii) This section does not prevent an accident and health insurer from:

1652 (A) adjusting the benefit payable under this section for cost sharing measures imposed
1653 under the policy or contract for maternity benefit coverage; or

1654 (B) providing additional adoption indemnity benefits including:

1655 (I) extending the period of time after birth in which a child must be placed with an
1656 insured; or

1657 (II) providing a benefit in excess of the amount specified in Subsection (1)(c).

1658 (b) An insurer that has paid the adoption indemnity benefit under Subsection (1)(a)
1659 may seek reimbursement of the benefit if:

1660 (i) the postplacement evaluation disapproves the adoption placement; and

1661 (ii) a court rules the adoption may not be finalized because of an act or omission of an
1662 adoptive parent or parents that affects the child's health or safety.

1663 (c) (i) The amount of the adoption indemnity benefit provided under Subsection (1) is
1664 \$4,000 subject to the adjustments permitted by Subsection (1)(a)(ii).

1665 (ii) An insurer may comply with the provisions of this section by providing the \$4,000
1666 adoption indemnity benefit to an enrollee to be used for the purpose of the enrollee obtaining
1667 infertility treatments rather than seeking reimbursement for an adoption in accordance with
1668 terms designated by the insurer.

1669 (d) Each insurer shall pay its pro rata share of the adoption indemnity benefit if each
1670 adoptive parent:

- 1671 (i) has coverage for maternity benefits with a different insurer; and
1672 (ii) makes a claim for the adoption indemnity benefit provided in Subsection (1)(a).
1673 (2) If a policy offers optional maternity benefits, it shall also offer coverage for
1674 adoption indemnity benefits if:
- 1675 (a) a child is placed for adoption with the insured within 90 days of the child's birth;
1676 and
1677 (b) the adoption is finalized within one year of the child's birth.
- 1678 (3) If an insured qualifies for the adoption indemnity benefit under this section and
1679 receives services from a [~~health care provider under contract with his insurer, the contracting~~
1680 ~~health care provider~~] network provider, the network provider may only collect from the insured
1681 the amount that the contracting health care provider is entitled to receive for such services
1682 under the contract, including any applicable copayment.
- 1683 [~~(4) For purposes of this section, "contracting health care provider" means:~~
1684 [~~(a) a "participating provider" as defined in Section 31A-8-101; or~~
1685 [~~(b) a "preferred health care provider" as described in Section 31A-22-617.~~]
- 1686 Section 9. Section **31A-22-610.5** is amended to read:
1687 **31A-22-610.5. Dependent coverage.**
- 1688 (1) As used in this section, "child" has the same meaning as defined in Section
1689 [78B-12-102](#).
- 1690 (2) (a) Any individual or group accident and health insurance policy or [~~health~~
1691 ~~maintenance~~] managed care organization contract that provides coverage for a policyholder's or
1692 certificate holder's dependent may not terminate coverage of an unmarried dependent by reason
1693 of the dependent's age before the dependent's 26th birthday and shall, upon application, provide
1694 coverage for all unmarried dependents up to age 26.
- 1695 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be
1696 included in the premium on the same basis as other dependent coverage.
- 1697 (c) This section does not prohibit the employer from requiring the employee to pay all
1698 or part of the cost of coverage for unmarried dependents.
- 1699 (d) An individual or group health insurance policy[~~, group health insurance policy, or~~
1700 ~~health maintenance~~] or managed care organization shall continue in force coverage for a
1701 dependent through the last day of the month in which the dependent ceases to be a dependent:

1702 (i) if premiums are paid; and
1703 (ii) notwithstanding [~~Section 31A-8-402.3, 31A-8-402.5, 31A-22-721, 31A-30-107.1,~~
1704 ~~or 31A-30-107.3~~] Sections 31A-22-618.6 and 31A-22-618.7.
1705 [~~(3) An individual or group accident and health insurance policy or health maintenance~~
1706 ~~organization contract shall reinstate dependent coverage, and for purposes of all exclusions and~~
1707 ~~limitations, shall treat the dependent as if the coverage had been in force since it was~~
1708 ~~terminated; if:~~
1709 [~~(a) the dependent has not reached the age of 26 by July 1, 1995;~~
1710 [~~(b) the dependent had coverage prior to July 1, 1994;~~
1711 [~~(c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the~~
1712 ~~age of the dependent; and]~~
1713 [~~(d) the policy has not been terminated since the dependent's coverage was terminated.]~~
1714 [~~(4)~~] (3) (a) When a parent is required by a court or administrative order to provide
1715 health insurance coverage for a child, an accident and health insurer may not deny enrollment
1716 of a child under the accident and health insurance plan of the child's parent on the grounds the
1717 child:
1718 (i) was born out of wedlock and is entitled to coverage under Subsection [~~(5)~~] (4);
1719 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child
1720 under the custodial parent's policy;
1721 (iii) is not claimed as a dependent on the parent's federal tax return; or
1722 (iv) does not reside with the parent or in the insurer's service area.
1723 (b) A child enrolled as required under Subsection [~~(4)~~] (3)(a)(iv) is subject to the terms
1724 of the accident and health insurance plan contract pertaining to services received outside of an
1725 insurer's service area. [~~A health maintenance organization shall comply with Section~~
1726 ~~31A-8-502.~~]
1727 [~~(5)~~] (4) When a child has accident and health coverage through an insurer of a
1728 noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer
1729 shall:
1730 (a) provide information to the custodial parent as necessary for the child to obtain
1731 benefits through that coverage, but the insurer or employer, or the agents or employees of either
1732 of them, are not civilly or criminally liable for providing information in compliance with this

1733 Subsection [~~(5)~~] (4)(a), whether the information is provided pursuant to a verbal or written
1734 request;

1735 (b) permit the custodial parent or the service provider, with the custodial parent's
1736 approval, to submit claims for covered services without the approval of the noncustodial
1737 parent; and

1738 (c) make payments on claims submitted in accordance with Subsection [~~(5)~~] (4)(b)
1739 directly to the custodial parent, the child who obtained benefits, the provider, or the state
1740 Medicaid agency.

1741 [~~(6)~~] (5) When a parent is required by a court or administrative order to provide health
1742 coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

1743 (a) permit the parent to enroll, under the family coverage, a child who is otherwise
1744 eligible for the coverage without regard to an enrollment season restrictions;

1745 (b) if the parent is enrolled but fails to make application to obtain coverage for the
1746 child, enroll the child under family coverage upon application of the child's other parent, the
1747 state agency administering the Medicaid program, or the state agency administering 42 U.S.C.
1748 Sec. 651 through 669, the child support enforcement program; and

1749 (c) (i) when the child is covered by an individual policy, not disenroll or eliminate
1750 coverage of the child unless the insurer is provided satisfactory written evidence that:

1751 (A) the court or administrative order is no longer in effect; or

1752 (B) the child is or will be enrolled in comparable accident and health coverage through
1753 another insurer which will take effect not later than the effective date of disenrollment; or

1754 (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of
1755 the child unless the employer is provided with satisfactory written evidence, which evidence is
1756 also provided to the insurer, that Subsection [~~(9)~~] (8)(c)(i), (ii)₂ or (iii) has happened.

1757 [~~(7)~~] (6) An insurer may not impose requirements on a state agency that has been
1758 assigned the rights of an individual eligible for medical assistance under Medicaid and covered
1759 for accident and health benefits from the insurer that are different from requirements applicable
1760 to an agent or assignee of any other individual so covered.

1761 [~~(8)~~] (7) Insurers may not reduce their coverage of pediatric vaccines below the benefit
1762 level in effect on May 1, 1993.

1763 [~~(9)~~] (8) When a parent is required by a court or administrative order to provide health

1764 coverage, which is available through an employer doing business in this state, the employer
1765 shall:

1766 (a) permit the parent to enroll under family coverage any child who is otherwise
1767 eligible for coverage without regard to any enrollment season restrictions;

1768 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,
1769 enroll the child under family coverage upon application by the child's other parent, by the state
1770 agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec.
1771 651 through 669, the child support enforcement program;

1772 (c) not disenroll or eliminate coverage of the child unless the employer is provided
1773 satisfactory written evidence that:

1774 (i) the court order is no longer in effect;

1775 (ii) the child is or will be enrolled in comparable coverage which will take effect no
1776 later than the effective date of disenrollment; or

1777 (iii) the employer has eliminated family health coverage for all of its employees; and

1778 (d) withhold from the employee's compensation the employee's share, if any, of
1779 premiums for health coverage and to pay this amount to the insurer.

1780 ~~[(10)]~~ (9) An order issued under Section 62A-11-326.1 may be considered a "qualified
1781 medical support order" for the purpose of enrolling a dependent child in a group accident and
1782 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income
1783 Security Act of 1974.

1784 ~~[(11)]~~ (10) This section does not affect any insurer's ability to require as a precondition
1785 of any child being covered under any policy of insurance that:

1786 (a) the parent continues to be eligible for coverage;

1787 (b) the child shall be identified to the insurer with adequate information to comply with
1788 this section; and

1789 (c) the premium shall be paid when due.

1790 ~~[(12)]~~ (11) The provisions of this section apply to employee welfare benefit plans as
1791 defined in Section 26-19-2.

1792 ~~[(13)]~~ (12) The commissioner shall adopt rules interpreting and implementing this
1793 section with regard to out-of-area court ordered dependent coverage.

1794 Section 10. Section 31A-22-613.5 is amended to read:

1795 **31A-22-613.5. Price and value comparisons of health insurance.**

1796 (1) (a) This section applies to all health benefit plans.

1797 (b) Subsection (2) applies to:

1798 (i) all health benefit plans; and

1799 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

1800 (2) ~~[(a)]~~ The commissioner shall promote informed consumer behavior and responsible

1801 health benefit plans by requiring an insurer issuing a health benefit plan to~~[(t)]~~ provide to all

1802 enrollees, ~~[prior to]~~ before enrollment in the health benefit plan, written disclosure of:

1803 ~~[(A)]~~ (a) restrictions or limitations on prescription drugs and biologics, including:

1804 ~~[(F)]~~ (i) the use of a formulary;

1805 ~~[(H)]~~ (ii) co-payments and deductibles for prescription drugs; and

1806 ~~[(HH)]~~ (iii) requirements for generic substitution;

1807 ~~[(B)]~~ (b) coverage limits under the plan;

1808 ~~[(C)]~~ (c) any limitation or exclusion of coverage, including:

1809 ~~[(F)]~~ (i) a limitation or exclusion for a secondary medical condition related to a

1810 limitation or exclusion from coverage; and

1811 ~~[(H)]~~ (ii) easily understood examples of a limitation or exclusion of coverage for a

1812 secondary medical condition; and

1813 ~~[(D)]~~ (d) whether the insurer permits an exchange of the adoption indemnity benefit in

1814 Section 31A-22-610.1 for infertility treatments, in accordance with Subsection

1815 31A-22-610.1(1)(c)(ii) and the terms associated with the exchange of benefits~~[- and]~~.

1816 ~~[(ii) provide the commissioner with:]~~

1817 ~~[(A) the information described in Subsections 31A-22-635(5) through (7) in the~~

1818 ~~standardized electronic format required by Subsection 63N-11-107(1); and]~~

1819 ~~[(B) information regarding insurer transparency in accordance with Subsection (4).]~~

1820 ~~[(b)]~~ (3) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in

1821 writing to the commissioner:

1822 ~~[(t)]~~ (a) upon commencement of operations in the state; and

1823 ~~[(tt)]~~ (b) anytime the insurer amends any of the following described in Subsection

1824 (2)~~[(a)(t)]~~:

1825 ~~[(A)]~~ (i) treatment policies;

1826 ~~[(B)]~~ (ii) practice standards;
 1827 ~~[(C)]~~ (iii) restrictions;
 1828 ~~[(D)]~~ (iv) coverage limits of the insurer's health benefit plan or health insurance policy;

1829 or

1830 ~~[(E)]~~ (v) limitations or exclusions of coverage including a limitation or exclusion for a
 1831 secondary medical condition related to a limitation or exclusion of the insurer's health
 1832 insurance plan.

1833 ~~[(e)]~~ (4) (a) An insurer shall provide the enrollee with notice of an increase in costs for
 1834 prescription drug coverage due to a change in benefit design under Subsection (2)(a)~~[(i)(A)]~~:

1835 (i) either:

1836 (A) in writing; or

1837 (B) on the insurer's website; and

1838 (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as
 1839 soon as reasonably possible.

1840 ~~[(d)]~~ (b) If under Subsection (2)(a)~~[(i)(A)]~~ a formulary is used, the insurer shall make
 1841 available to prospective enrollees and maintain evidence of the fact of the disclosure of:

1842 (i) the drugs included;

1843 (ii) the patented drugs not included;

1844 (iii) any conditions that exist as a precedent to coverage; and

1845 (iv) any exclusion from coverage for secondary medical conditions that may result
 1846 from the use of an excluded drug.

1847 ~~[(e)]~~ (c) (i) The commissioner shall develop examples of limitations or exclusions of a
 1848 secondary medical condition that an insurer may use under Subsection (2)~~[(a)(i)(C)]~~(c).

1849 (ii) Examples of a limitation or exclusion of coverage provided under Subsection
 1850 (2)~~[(a)(i)(C)]~~(c) or otherwise are for illustrative purposes only, and the failure of a particular
 1851 fact situation to fall within the description of an example does not, by itself, support a finding
 1852 of coverage.

1853 ~~[(3) The commissioner:]~~

1854 ~~[(a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to~~
 1855 ~~the Health Insurance Exchange created under Section 63N-11-104; and]~~

1856 ~~[(b) may request information from an insurer to verify the information submitted by the~~

1857 insurer under this section.]

1858 ~~[(4) The commissioner shall:]~~

1859 ~~[(a) convene a group of insurers, a member representing the Public Employees' Benefit~~
1860 ~~and Insurance Program, consumers, and an organization that provides multipayer and~~
1861 ~~multiprovider quality assurance and data collection, to develop information for consumers to~~
1862 ~~compare health insurers and health benefit plans on the Health Insurance Exchange, which~~
1863 ~~shall include consideration of:]~~

1864 ~~[(i) the number and cost of an insurer's denied health claims;]~~

1865 ~~[(ii) the cost of denied claims that is transferred to providers;]~~

1866 ~~[(iii) the average out-of-pocket expenses incurred by participants in each health benefit~~
1867 ~~plan that is offered by an insurer in the Health Insurance Exchange;]~~

1868 ~~[(iv) the relative efficiency and quality of claims administration and other~~
1869 ~~administrative processes for each insurer offering plans in the Health Insurance Exchange; and]~~

1870 ~~[(v) consumer assessment of each insurer or health benefit plan;]~~

1871 ~~[(b) adopt an administrative rule that establishes:]~~

1872 ~~[(i) definition of terms;]~~

1873 ~~[(ii) the methodology for determining and comparing the insurer transparency~~
1874 ~~information;]~~

1875 ~~[(iii) the data, and format of the data, that an insurer shall submit to the commissioner~~
1876 ~~in order to facilitate the consumer comparison on the Health Insurance Exchange in accordance~~
1877 ~~with Section [63N-11-107](#); and]~~

1878 ~~[(iv) the dates on which the insurer shall submit the data to the commissioner in order~~
1879 ~~for the commissioner to transmit the data to the Health Insurance Exchange in accordance with~~
1880 ~~Section [63N-11-107](#); and]~~

1881 ~~[(c) implement the rules adopted under Subsection (4)(b) in a manner that protects the~~
1882 ~~business confidentiality of the insurer.]~~

1883 Section 11. Section **31A-22-618** is amended to read:

1884 **31A-22-618. Nondiscrimination among health care professionals.**

1885 ~~[(1)]~~ Except as provided under Section [~~31A-22-617~~] [31A-45-303](#) and Subsection [~~(3)~~
1886 ~~of this section~~] (2), and except as to insurers licensed under Chapter 8, Health Maintenance
1887 Organizations and Limited Health Plans, no insurer may unfairly discriminate against any

1888 licensed class of health care providers by structuring contract exclusions which exclude
 1889 payment of benefits for the treatment of any illness, injury, or condition by any licensed class
 1890 of health care providers when the treatment is within the scope of the licensee's practice and the
 1891 illness, injury, or condition falls within the coverage of the contract. Upon the written request
 1892 of an insured alleging an insurer has violated this section, the commissioner shall hold a
 1893 hearing to determine if the violation exists. The commissioner may consolidate two or more
 1894 related alleged violations into a single hearing.

1895 ~~[(2) This section does not apply to catastrophic mental health coverage provided in~~
 1896 ~~accordance with Section 31A-22-625.]~~

1897 ~~[(3)]~~ (2) Coverage for licensed providers for behavioral analysis may be limited by a
 1898 insurer in accordance with Section 58-61-714. Nothing in this section prohibits an insurer
 1899 from electing to provide coverage for other licensed professionals whose scope of practice
 1900 includes behavior analysis.

1901 Section 12. Section 31A-22-618.5 is amended to read:

1902 **31A-22-618.5. Coverage of insurance mandates imposed after January 1, 2009.**

1903 (1) The purpose of this section is to increase the range of health benefit plans available
 1904 in the small group, small employer group, large group, and individual insurance markets.

1905 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
 1906 Organizations and Limited Health Plans:

1907 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
 1908 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
 1909 and

1910 (b) may offer to a potential purchaser one or more health benefit plans that:

1911 (i) are not subject to one or more of the following:

1912 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4); or

1913 ~~[(B) the limitation on point of service products in Subsections 31A-8-408(3) through~~
 1914 ~~(6);]~~

1915 ~~[(C)]~~ (B) except as provided in Subsection (2)(b)(ii), basic health care services as
 1916 defined in Section 31A-8-101; or

1917 ~~[(D)]~~ (C) coverage mandates enacted after January 1, 2009 that are not required by
 1918 federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the

1919 mandate enacted after January 1, 2009; and

1920 (ii) when offering a health plan under this section, provide coverage for an emergency
1921 medical condition as required by Section [31A-22-627](#) [as follows]:

1922 [~~(A) within the organization's service area, covered services shall include health care
1923 services from nonaffiliated providers when medically necessary to stabilize an emergency
1924 medical condition; and]~~

1925 [~~(B) outside the organization's service area, covered services shall include medically
1926 necessary health care services for the treatment of an emergency medical condition that are
1927 immediately required while the enrollee is outside the geographic limits of the organization's
1928 service area.]~~

1929 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
1930 Maintenance Organizations and Limited Health Plans:

1931 (a) may offer a health benefit plan that is not subject to Section [31A-22-618](#) and
1932 Subsection [31A-45-303\(3\)\(b\)\(iii\)](#);

1933 (b) when offering a health plan under this Subsection (3), shall provide coverage of
1934 emergency care services as required by Section [31A-22-627](#); and

1935 (c) is not subject to coverage mandates enacted after January 1, 2009 that are not
1936 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
1937 after January 1, 2009.

1938 (4) Section [31A-8-106](#) does not prohibit the offer of a health benefit plan under
1939 Subsection (2)(b).

1940 (5) (a) Any difference in price between a health benefit plan offered under Subsections
1941 (2)(a) and (b) shall be based on actuarially sound data.

1942 (b) Any difference in price between a health benefit plan offered under Subsection
1943 (3)(a) shall be based on actuarially sound data.

1944 (6) Nothing in this section limits the number of health benefit plans that an insurer may
1945 offer.

1946 Section 13. Section [31A-22-618.6](#), which is renumbered from Section [31A-8-402.3](#) is
1947 renumbered and amended to read:

1948 [~~[31A-8-402.3](#)]. [31A-22-618.6](#). **Discontinuance, nonrenewal, or changes to**
1949 **group health benefit plans.**~~

1950 (1) Except as otherwise provided in this section, a group health benefit plan for a plan
1951 sponsor is renewable and continues in force:

1952 (a) with respect to all eligible employees and dependents; and

1953 (b) at the option of the plan sponsor.

1954 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed [~~for a~~
1955 ~~network plan, if~~]:

1956 (a) for noncompliance with the insurer's employer contribution requirements;

1957 [~~(a)~~] (b) if there is no longer any enrollee under the group health plan who lives,
1958 resides, or works in:

1959 (i) the service area of the insurer; or

1960 (ii) the area for which the insurer is authorized to do business; [~~or~~]

1961 [~~(b)~~] (c) for coverage made available in the small or large employer market only
1962 through an association, if:

1963 (i) the employer's membership in the association ceases; and

1964 (ii) the coverage is terminated uniformly without regard to any health status-related
1965 factor relating to any covered individual[-]; or

1966 (d) for noncompliance with the insurer's minimum employee participation
1967 requirements, except as provided in Subsection (3).

1968 (3) If a small employer employs fewer than two eligible employees, a carrier may not
1969 discontinue or not renew the health benefit plan until the first renewal date following the
1970 beginning of a new plan year, even if the carrier knows at the beginning of the plan year that
1971 the employer no longer has at least two current employees.

1972 (4) (a) A small employer that, after purchasing a health benefit plan in the small group
1973 market, employs on average more than 50 eligible employees on each business day in a
1974 calendar year may continue to renew the health benefit plan purchased in the small group
1975 market.

1976 (b) A large employer that, after purchasing a health benefit plan in the large group
1977 market, employs on average fewer than 51 eligible employees on each business day in a
1978 calendar year may continue to renew the health benefit plan purchased in the large group
1979 market.

1980 [~~(3)~~] (5) A health benefit plan for a plan sponsor may be discontinued if:

- 1981 (a) a condition described in Subsection (2) exists;
- 1982 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
- 1983 terms of the contract;
- 1984 (c) the plan sponsor:
- 1985 (i) performs an act or practice that constitutes fraud; or
- 1986 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 1987 coverage;
- 1988 (d) the insurer:
- 1989 (i) elects to discontinue offering a particular health benefit plan product delivered or
- 1990 issued for delivery in this state; and
- 1991 (ii) (A) provides notice of the discontinuation in writing~~[:(F)]~~ to each plan sponsor,
- 1992 employee, or dependent of a plan sponsor or an employee~~[:and (H)]~~, at least 90 days before the
- 1993 date the coverage will be discontinued;
- 1994 (B) provides notice of the discontinuation in writing~~[:(F)]~~ to the commissioner~~[:and~~
- 1995 ~~(H)]~~, and at least three working days [~~prior to~~] before the date the notice is sent to the affected
- 1996 plan sponsors, employees, and dependents of the plan sponsors or employees;
- 1997 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase~~[:~~
- 1998 ~~(F)]~~ all other health benefit plan products currently being offered by the insurer in the market~~[:~~
- 1999 ~~or (H)]~~ or, in the case of a large employer, any other health benefit ~~H~~ → **[plan product]**
- 1999a **plans** ← ~~H~~ currently being
- 2000 offered in that market; and
- 2001 (D) in exercising the option to discontinue that product and in offering the option of
- 2002 coverage in this section, acts uniformly without regard to~~[:(F)]~~ the claims experience of a plan
- 2003 sponsor~~[:(H)]~~, any health status-related factor relating to any covered participant or
- 2004 beneficiary~~[:or (H)]~~, or any health status-related factor relating to any new participant or
- 2005 beneficiary who may become eligible for the coverage; or
- 2006 (e) the insurer:
- 2007 (i) elects to discontinue all of the insurer's health benefit plans in:
- 2008 (A) the small employer market;
- 2009 (B) the large employer market; or
- 2010 (C) both the small employer and large employer markets; and
- 2011 (ii) (A) provides notice of the discontinuation in writing~~[:(F)]~~ to each plan sponsor,

2012 employee, or dependent of a plan sponsor or an employee[~~;~~ and ~~(H)~~] at least 180 days before
2013 the date the coverage will be discontinued;

2014 (B) provides notice of the discontinuation in writing[~~;~~ ~~(F)~~] to the commissioner in each
2015 state in which an affected insured individual is known to reside[~~;~~ and ~~(H)~~] and, at least 30
2016 working days [~~prior to~~] before the date the notice is sent to the affected plan sponsors,
2017 employees, and the dependents of the plan sponsors or employees;

2018 (C) discontinues and nonrenews all plans issued or delivered for issuance in the market
2019 described in Subsection (5)(e)(i); and

2020 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

2021 [~~(4) A large employer health benefit plan may be discontinued or nonrenewed:~~]

2022 [~~(a) if a condition described in Subsection (2) exists; or~~]

2023 [~~(b) for noncompliance with the insurer's:~~]

2024 [~~(i) minimum participation requirements; or~~]

2025 [~~(ii) employer contribution requirements.~~]

2026 [~~(5) A small employer health benefit plan may be discontinued or nonrenewed:~~]

2027 [~~(a) if a condition described in Subsection (2) exists; or~~]

2028 [~~(b) for noncompliance with the insurer's employer contribution requirements.~~]

2029 [~~(6) A small employer health benefit plan may be nonrenewed:~~]

2030 [~~(a) if a condition described in Subsection (2) exists; or~~]

2031 [~~(b) for noncompliance with the insurer's minimum participation requirements.~~]

2032 [~~(7)~~] (6) (a) Except as provided in Subsection [~~(7)~~] (6)(d), an eligible employee may be
2033 discontinued if after issuance of coverage the eligible employee:

2034 (i) engages in an act or practice in connection with the coverage that constitutes fraud;

2035 or

2036 (ii) makes an intentional misrepresentation of material fact in connection with the
2037 coverage.

2038 (b) An eligible employee that is discontinued under Subsection [~~(7)~~] (6)(a) may
2039 reenroll:

2040 (i) 12 months after the date of discontinuance; and

2041 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
2042 to reenroll.

2043 (c) At the time the eligible employee's coverage is discontinued under Subsection [(7)]
 2044 (6)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
 2045 discontinued.

2046 (d) An eligible employee may not be discontinued under this Subsection [(7)] (6)
 2047 because of a fraud or misrepresentation that relates to health status.

2048 [(8)] (7) For purposes of this section, a reference to "plan sponsor" includes a reference
 2049 to the employer:

2050 (a) with respect to coverage provided to an employer member of the association; and

2051 (b) if the health benefit plan is made available by an insurer in the employer market
 2052 only through:

2053 (i) an association;

2054 (ii) a trust; or

2055 (iii) a discretionary group.

2056 [(9)] (8) An insurer may modify a health benefit plan for a plan sponsor only:

2057 (a) at the time of coverage renewal; and

2058 (b) if the modification is effective uniformly among all plans with that product.

2059 Section 14. Section ~~31A-22-618.7~~, which is renumbered from Section 31A-8-402.5 is
 2060 renumbered and amended to read:

2061 ~~[31A-8-402.5]~~. **31A-22-618.7. Individual discontinuance and nonrenewal.**

2062 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an
 2063 individual basis is renewable and continues in force:

2064 (i) with respect to all [~~individuals~~] enrollees or dependents; and

2065 (ii) at the option of the [~~individual~~] enrollee.

2066 (b) Subsection (1)(a) applies regardless of:

2067 (i) whether the contract is issued through:

2068 (A) a trust;

2069 (B) an association;

2070 (C) a discretionary group; or

2071 (D) other similar grouping; or

2072 (ii) the situs of delivery of the policy or contract.

2073 (2) [~~A~~] An individual health benefit plan may be discontinued or nonrenewed:

- 2074 (a) ~~[for a network plan,]~~ if:
- 2075 (i) ~~[the individual no longer]~~ there is no longer an enrollee under the individual health
- 2076 benefit plan who lives, resides, or works in:
- 2077 (A) the service area of the insurer; or
- 2078 (B) the area for which the insurer is authorized to do business; and
- 2079 (ii) coverage is terminated uniformly without regard to any health status-related factor
- 2080 relating to any covered ~~[individual]~~ enrollee; or
- 2081 (b) for coverage made available through an association, if:
- 2082 (i) the ~~[individual's]~~ enrollee's membership in the association ceases; and
- 2083 (ii) the coverage is terminated uniformly without regard to any health status-related
- 2084 factor relating to any covered ~~[individual]~~ enrollee.
- 2085 (3) ~~[A]~~ An individual health benefit plan may be discontinued if:
- 2086 (a) a condition described in Subsection (2) exists;
- 2087 (b) the ~~[individual]~~ enrollee fails to pay premiums or contributions in accordance with
- 2088 the terms of the health benefit plan, including any timeliness requirements;
- 2089 (c) the ~~[individual]~~ enrollee:
- 2090 (i) performs an act or practice in connection with the coverage that constitutes fraud; or
- 2091 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 2092 coverage;
- 2093 (d) the insurer:
- 2094 (i) elects to discontinue offering a particular health benefit ~~[product]~~ plan product
- 2095 delivered or issued for delivery in this state; and
- 2096 (ii) (A) provides notice of the discontinuation in writing~~[-(F)]~~ to each ~~[individual]~~
- 2097 enrollee provided coverage~~[-and (H)]~~ at least 90 days before the date the coverage will be
- 2098 discontinued;
- 2099 (B) provides notice of the discontinuation in writing~~[-(F)]~~ to the commissioner~~[-and~~
- 2100 ~~(H)]~~ and, at least three working days ~~[prior to]~~ before the date the notice is sent₂ to the affected
- 2101 ~~[individuals]~~ enrollees;
- 2102 (C) offers to each covered ~~[individual]~~ enrollee on a guaranteed issue basis~~[-]~~ the
- 2103 option to purchase all other individual health benefit ~~Ĥ~~→ [plan products] plans ←~~Ĥ~~ currently
- 2103a being offered by
- 2104 the insurer for individuals in that market; and

2105 (D) acts uniformly without regard to any health status-related factor of covered
 2106 ~~[individuals]~~ enrollees or dependents of covered ~~[individuals]~~ enrollees who may become
 2107 eligible for coverage; or

2108 (e) the insurer:

2109 (i) elects to discontinue all of the insurer's health benefit plans in the individual market;
 2110 and

2111 (ii) (A) provides notice of the discontinuation in writing~~[-(F)]~~ to each ~~[individual]~~
 2112 enrollee provided coverage~~[-and (H)]~~ at least 180 days before the date the coverage will be
 2113 discontinued;

2114 (B) provides notice of the discontinuation in writing~~[-(F)]~~ to the commissioner in each
 2115 state in which an affected ~~[insured individual]~~ enrollee is known to reside~~[-and (H)]~~ and, at
 2116 least 30 working days ~~[prior to]~~ before the date the notice is sent, to the affected ~~[individuals]~~
 2117 enrollees;

2118 (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers
 2119 for issuance in the individual market; and

2120 (D) acts uniformly without regard to any health status-related factor of covered
 2121 ~~[individuals]~~ enrollees or dependents of covered ~~[individuals]~~ enrollees who may become
 2122 eligible for coverage.

2123 (4) An insurer may modify an individual health benefit plan only:

2124 (a) at the time of coverage renewal; and

2125 (b) if the modification is effective uniformly among all health benefit plans.

2126 Section 15. Section **31A-22-618.8**, which is renumbered from Section 31A-8-402.7 is
 2127 renumbered and amended to read:

2128 ~~[31A-8-402.7]~~. **31A-22-618.8. Discontinuance and nonrenewal limitations.**

2129 (1) Subject to Section **31A-4-115**, an insurer that elects to discontinue offering a health
 2130 benefit plan under Subsections ~~[31A-8-402.3]~~ **31A-22-618.6**(3)(e) and ~~[31A-8-402.5]~~
 2131 **31A-22-618.7**(3)(e) is prohibited from writing new business:

2132 (a) in the market in this state for which the insurer discontinues or does not renew; and

2133 (b) for a period of five years beginning on the date of discontinuation of the last
 2134 coverage that is discontinued.

2135 (2) If an insurer is doing business in one established geographic service area of the

2136 state, Sections [~~31A-8-402.3 and 31A-8-402.5~~] 31A-22-618.6 and 31A-22-618.7 apply only to
2137 the insurer's operations in that service area.

2138 (3) The commissioner may, by rule or order, define the scope of service area.

2139 Section 16. Section **31A-22-627** is amended to read:

2140 **31A-22-627. Coverage of emergency medical services.**

2141 (1) A health insurance policy or [~~health maintenance~~] managed care organization
2142 contract:

2143 (a) shall provide, at a minimum, coverage of emergency services as required in 29
2144 C.F.R. Sec. 2590.715-2719A; and

2145 (b) may not:

2146 (i) require any form of preauthorization for treatment of an emergency medical
2147 condition until after the insured's condition has been stabilized; or

2148 (ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered
2149 treatment considered medically necessary to stabilize the emergency medical condition of an
2150 insured.

2151 (2) A health insurance policy or [~~health maintenance~~] managed care organization
2152 contract may require authorization for the continued treatment of an emergency medical
2153 condition after the insured's condition has been stabilized. If such authorization is required, an
2154 insurer who does not accept or reject a request for authorization may not deny a claim for any
2155 evaluation, diagnostic testing, or other treatment considered medically necessary that occurred
2156 between the time the request was received and the time the insurer rejected the request for
2157 authorization.

2158 (3) For purposes of this section:

2159 (a) "Emergency medical condition" means a medical condition manifesting itself by
2160 acute symptoms of sufficient severity, including severe pain, such that a prudent layperson,
2161 who possesses an average knowledge of medicine and health, would reasonably expect the
2162 absence of immediate medical attention at a hospital emergency department to result in:

2163 (i) placing the insured's health, or with respect to a pregnant woman, the health of the
2164 woman or her unborn child, in serious jeopardy;

2165 (ii) serious impairment to bodily functions; or

2166 (iii) serious dysfunction of any bodily organ or part[~~; and~~].

2167 (b) "Hospital emergency department" means that area of a hospital in which emergency
2168 services are provided on a 24-hour-a-day basis.

2169 (c) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).

2170 (4) Nothing in this section may be construed as:

2171 (a) altering the level or type of benefits that are provided under the terms of a contract
2172 or policy; or

2173 (b) restricting a policy or contract from providing enhanced benefits for certain
2174 emergency medical conditions that are identified in the policy or contract.

2175 (5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has
2176 violated this section, the commissioner may:

2177 (a) work with the insurer to improve the insurer's compliance with this section; or

2178 (b) impose the following fines:

2179 (i) not more than \$5,000; or

2180 (ii) twice the amount of any profit gained from violations of this section.

2181 Section 17. Section 31A-22-628 is amended to read:

2182 **31A-22-628. Standing referral to a specialist.**

2183 (1) With respect to a health insurance policy or [~~health maintenance~~] managed care
2184 organization contract that does not allow an insured to have direct access to a health care
2185 specialist, the insurer shall establish and implement a procedure by which an insured may
2186 obtain a standing referral to a health care specialist.

2187 (2) The procedure established under Subsection (1):

2188 (a) shall provide for a standing referral to a specialist if the insured's primary care
2189 provider determines, in consultation with the specialist, that the insured needs continuing care
2190 from the specialist; and

2191 (b) may require the insurer's approval of a treatment plan designed by the specialist, in
2192 consultation with the primary care provider and the insured, which may include:

2193 (i) a limit on the number of visits to the specialist;

2194 (ii) a time limit on the duration of the referral; and

2195 (iii) mandatory updates on the insured's condition.

2196 Section 18. Section 31A-22-635 is amended to read:

2197 **31A-22-635. Uniform application -- Uniform waiver of coverage.**

2198 (1) For purposes of this section, "insurer":
 2199 (a) is defined in Subsection 31A-22-634(1); and
 2200 (b) includes the state employee's risk pool under Section 49-20-202.

2201 (2) (a) Insurers offering a health benefit plan to an individual or small employer shall
 2202 use a uniform application form.

2203 (b) The uniform application form:
 2204 (i) may not include questions about an applicant's health history; and
 2205 (ii) shall be shortened and simplified in accordance with rules adopted by the
 2206 commissioner.

2207 (c) Insurers offering a health benefit plan to a small employer shall use a uniform
 2208 waiver of coverage form, which may not include health status related questions, and is limited
 2209 to:

2210 (i) information that identifies the employee;
 2211 (ii) proof of the employee's insurance coverage; and
 2212 (iii) a statement that the employee declines coverage with a particular employer group.

2213 (3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and
 2214 uniform waiver of coverage forms may, if the combination or modification is approved by the
 2215 commissioner, be combined or modified to facilitate a more efficient and consumer friendly
 2216 experience for ~~[(a) enrollees using the Health Insurance Exchange; or (b)]~~ insurers using
 2217 electronic applications.

2218 (4) (a) The uniform application form, and uniform waiver form, shall be adopted and
 2219 approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative
 2220 Rulemaking Act.

2221 ~~[(5) (a) An insurer who offers a health benefit plan on the Health Insurance Exchange
 2222 created in Section 63N-11-104, shall:]~~

2223 ~~[(i) accept and process an electronic submission of the uniform application or uniform
 2224 waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to
 2225 Section 63N-11-107;]~~

2226 ~~[(ii) if requested, provide the applicant with a copy of the completed application either
 2227 by mail or electronically;]~~

2228 ~~[(iii) post all health benefit plans offered by the insurer in the defined contribution~~

2229 arrangement market on the Health Insurance Exchange; and]

2230 ~~[(iv) post the information required by Subsection (6) on the Health Insurance Exchange~~

2231 ~~for every health benefit plan the insurer offers on the Health Insurance Exchange.]~~

2232 ~~[(b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans~~

2233 ~~on the Health Insurance Exchange may not directly or indirectly offer products on the Health~~

2234 ~~Insurance Exchange that are not health benefit plans.]~~

2235 ~~[(c) Notwithstanding Subsection (5)(b):]~~

2236 ~~[(i) an insurer may offer a health savings account on the Health Insurance Exchange;]~~

2237 ~~[(ii) an insurer may offer dental plans on the Health Insurance Exchange; and]~~

2238 ~~[(iii) the department may make administrative rules to regulate the offer of dental plans~~

2239 ~~on the Health Insurance Exchange.]~~

2240 ~~[(6) An insurer shall provide the commissioner and the Health Insurance Exchange~~

2241 ~~with the following information for each health benefit plan submitted to the Health Insurance~~

2242 ~~Exchange, in the electronic format required by Subsection ~~63N-11-107(1)~~:]~~

2243 ~~[(a) plan design, benefits, and options offered by the health benefit plan including state~~

2244 ~~mandates the plan does not cover;]~~

2245 ~~[(b) information and Internet address to online provider networks;]~~

2246 ~~[(c) wellness programs and incentives;]~~

2247 ~~[(d) descriptions of prescription drug benefits, exclusions, or limitations;]~~

2248 ~~[(e) the percentage of claims paid by the insurer within 30 days of the date a claim is~~

2249 ~~submitted to the insurer for the prior year; and]~~

2250 ~~[(f) the claims denial and insurer transparency information developed in accordance~~

2251 ~~with Subsection ~~31A-22-613.5(4)~~:]~~

2252 ~~[(7) The department shall post on the Health Insurance Exchange the department's~~

2253 ~~solvency rating for each insurer who posts a health benefit plan on the Health Insurance~~

2254 ~~Exchange. The solvency rating for each insurer shall be based on methodology established by~~

2255 ~~the department by administrative rule and shall be updated each calendar year.]~~

2256 ~~[(8) (a) The commissioner may request information from an insurer under Section~~

2257 ~~~~31A-22-613.5~~ to verify the data submitted to the department and to the Health Insurance~~

2258 ~~Exchange.]~~

2259 (b) The commissioner shall regulate the fees charged by insurers to an enrollee for a

2260 uniform application form or electronic submission of the application forms.

2261 Section 19. Section **31A-22-642** is amended to read:

2262 **31A-22-642. Insurance coverage for autism spectrum disorder.**

2263 (1) As used in this section:

2264 (a) "Applied behavior analysis" means the design, implementation, and evaluation of
2265 environmental modifications, using behavioral stimuli and consequences, to produce socially
2266 significant improvement in human behavior, including the use of direct observation,
2267 measurement, and functional analysis of the relationship between environment and behavior.

2268 (b) "Autism spectrum disorder" means pervasive developmental disorders as defined
2269 by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders
2270 (DSM).

2271 (c) "Behavioral health treatment" means counseling and treatment programs, including
2272 applied behavior analysis, that are:

2273 (i) necessary to develop, maintain, or restore, to the maximum extent practicable, the
2274 functioning of an individual; and

2275 (ii) provided or supervised by a:

2276 (A) board certified behavior analyst; or

2277 (B) person licensed under Title 58, Chapter 1, Division of Occupational and
2278 Professional Licensing Act, whose scope of practice includes mental health services.

2279 (d) "Diagnosis of autism spectrum disorder" means medically necessary assessments,
2280 evaluations, or tests:

2281 (i) performed by a licensed physician who is board certified in neurology, psychiatry,
2282 or pediatrics and has experience diagnosing autism spectrum disorder, or a licensed
2283 psychologist with experience diagnosing autism spectrum disorder; and

2284 (ii) necessary to diagnose whether an individual has an autism spectrum disorder.

2285 (e) "Pharmacy care" means medications prescribed by a licensed physician and any
2286 health-related services considered medically necessary to determine the need or effectiveness
2287 of the medications.

2288 (f) "Psychiatric care" means direct or consultative services provided by a psychiatrist
2289 licensed in the state in which the psychiatrist practices.

2290 (g) "Psychological care" means direct or consultative services provided by a

2291 psychologist licensed in the state in which the psychologist practices.

2292 (h) "Therapeutic care" means services provided by licensed or certified speech
2293 therapists, occupational therapists, or physical therapists.

2294 (i) "Treatment for autism spectrum disorder":

2295 (i) means evidence-based care and related equipment prescribed or ordered for an
2296 individual diagnosed with an autism spectrum disorder by a physician or a licensed
2297 psychologist described in Subsection (1)(d) who determines the care to be medically necessary;
2298 and

2299 (ii) includes:

2300 (A) behavioral health treatment, provided or supervised by a person described in
2301 Subsection (1)(c)(ii);

2302 (B) pharmacy care;

2303 (C) psychiatric care;

2304 (D) psychological care; and

2305 (E) therapeutic care.

2306 (2) Notwithstanding the provisions of Section [31A-22-618.5](#), a health benefit plan
2307 offered in the individual market or the large group market and entered into or renewed on or
2308 after January 1, 2016, shall provide coverage for the diagnosis and treatment of autism
2309 spectrum disorder:

2310 (a) for a child who is at least two years old, but younger than 10 years old; and

2311 (b) in accordance with the requirements of this section and rules made by the
2312 commissioner.

2313 (3) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah
2314 Administrative Rulemaking Act, to set the minimum standards of coverage for the treatment of
2315 autism spectrum disorder.

2316 (4) Subject to Subsection (5), the rules described in Subsection (3) shall establish
2317 durational limits, amount limits, deductibles, copayments, and coinsurance for the treatment of
2318 autism spectrum disorder that are similar to, or identical to, the coverage provided for other
2319 illnesses or diseases.

2320 (5) (a) Coverage for behavioral health treatment for a person with an autism spectrum
2321 disorder shall cover at least 600 hours a year. Other terms and conditions in the health benefit

2322 plan that apply to other benefits covered by the health benefit plan apply to coverage required
2323 by this section.

2324 (b) Notwithstanding [~~Subsection 31A-22-617(6)~~] Section 31A-45-303, a health benefit
2325 plan providing treatment under Subsection (5)(a) shall include in the plan's provider network
2326 both board certified behavior analysts and mental health providers qualified under Subsection
2327 (1)(c)(ii).

2328 (6) A health care provider shall submit a treatment plan for autism spectrum disorder to
2329 the insurer within 14 business days of starting treatment for an individual. If an individual is
2330 receiving treatment for an autism spectrum disorder, an insurer shall have the right to request a
2331 review of that treatment not more than once every six months. A review of treatment under
2332 this Subsection (6) may include a review of treatment goals and progress toward the treatment
2333 goals. If an insurer makes a determination to stop treatment as a result of the review of the
2334 treatment plan under this subsection, the determination of the insurer may be reviewed under
2335 Section 31A-22-629.

2336 (7) (a) In accordance with Subsection (7)(b), the commissioner shall waive the
2337 requirements of this section for all insurers in the individual market or the large group market,
2338 if an insurer demonstrates to the commissioner that the insurer's entire pool of business in the
2339 individual market or the large group market has incurred claims for the autism coverage
2340 required by this section in a 12 consecutive month period that will cause a premium increase
2341 for the insurer's entire pool of business in the individual market or the large group market in
2342 excess of 1% over the insurer's premiums in the previous 12 consecutive month period.

2343 (b) The commissioner shall waive the requirements of this section if:

2344 (i) after a public hearing in accordance with Title 63G, Chapter 4, Administrative
2345 Procedures Act, the commissioner finds that the insurer has demonstrated to the commissioner
2346 based on generally accepted actuarial principles and methodologies that the insurer's entire pool
2347 of business in the individual market or the large group market will experience a premium
2348 increase of 1% or greater as a result of the claims for autism services as described in this
2349 section; or

2350 (ii) the attorney general issues a legal opinion that the limits under Subsection (5)(a)
2351 cannot be implemented by an insurer in a manner that complies with federal law.

2352 (8) If a waiver is granted under Subsection (7), the insurer may:

2353 (a) continue to offer autism coverage under the existing plan until the next renewal
2354 period for the plan, at which time the insurer:

2355 (i) may delete the autism coverage from the plan without having to re-apply for the
2356 waiver under Subsection (7); and

2357 (ii) file the plan with the commissioner in accordance with guidelines issued by the
2358 commissioner;

2359 (b) discontinue offering plans subject to Subsection (2), no earlier than the next
2360 calendar quarter following the date the waiver is granted, subject to filing guidelines issued by
2361 the commissioner; or

2362 (c) nonrenew existing plans that are subject to Subsection (2), in compliance with
2363 Subsection [~~31A-30-107(3)(d)~~] 31A-22-618.6(5) or Subsection 31A-22-618.7(3).

2364 (9) This section sunsets in accordance with Section ~~63I-1-231~~.

2365 Section 20. Section ~~31A-23a-402~~ is amended to read:

2366 **31A-23a-402. Unfair marketing practices -- Communication -- Unfair**
2367 **discrimination -- Coercion or intimidation -- Restriction on choice.**

2368 (1) (a) (i) Any of the following may not make or cause to be made any communication
2369 that contains false or misleading information, relating to an insurance product or contract, any
2370 insurer, or any licensee under this title, including information that is false or misleading
2371 because it is incomplete:

2372 (A) a person who is or should be licensed under this title;

2373 (B) an employee or producer of a person described in Subsection (1)(a)(i)(A);

2374 (C) a person whose primary interest is as a competitor of a person licensed under this
2375 title; and

2376 (D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).

2377 (ii) As used in this Subsection (1), "false or misleading information" includes:

2378 (A) assuring the nonobligatory payment of future dividends or refunds of unused
2379 premiums in any specific or approximate amounts, but reporting fully and accurately past
2380 experience is not false or misleading information; and

2381 (B) with intent to deceive a person examining it:

2382 (I) filing a report;

2383 (II) making a false entry in a record; or

- 2384 (III) wilfully refraining from making a proper entry in a record.
- 2385 (iii) A licensee under this title may not:
- 2386 (A) use any business name, slogan, emblem, or related device that is misleading or
- 2387 likely to cause the insurer or other licensee to be mistaken for another insurer or other licensee
- 2388 already in business; or
- 2389 (B) use any name, advertisement, or other insurance promotional material that would
- 2390 cause a reasonable person to mistakenly believe that a state or federal government agency,
- 2391 including [~~the Health Insurance Exchange, also called the "Utah Health Exchange" or~~ Utah's
- 2392 small employer health insurance exchange known as "Avenue H," [~~created in Section~~
- 2393 63N-11-104, the Comprehensive Health Insurance Pool created in Chapter 29, Comprehensive
- 2394 Health Insurance Pool Act,] and the Children's Health Insurance Program created in Title 26,
- 2395 Chapter 40, Utah Children's Health Insurance Act:
- 2396 (I) is responsible for the insurance sales activities of the person;
- 2397 (II) stands behind the credit of the person;
- 2398 (III) guarantees any returns on insurance products of or sold by the person; or
- 2399 (IV) is a source of payment of any insurance obligation of or sold by the person.
- 2400 (iv) A person who is not an insurer may not assume or use any name that deceptively
- 2401 implies or suggests that person is an insurer.
- 2402 (v) A person other than persons licensed as health maintenance organizations under
- 2403 Chapter 8, Health Maintenance Organizations and Limited Health Plans, may not use the term
- 2404 "Health Maintenance Organization" or "HMO" in referring to itself.
- 2405 (b) A licensee's violation creates a rebuttable presumption that the violation was also
- 2406 committed by the insurer if:
- 2407 (i) the licensee under this title distributes cards or documents, exhibits a sign, or
- 2408 publishes an advertisement that violates Subsection (1)(a), with reference to a particular
- 2409 insurer:
- 2410 (A) that the licensee represents; or
- 2411 (B) for whom the licensee processes claims; and
- 2412 (ii) the cards, documents, signs, or advertisements are supplied or approved by that
- 2413 insurer.
- 2414 (2) (a) A title insurer, individual title insurance producer, or agency title insurance

2415 producer or any officer or employee of the title insurer, individual title insurance producer, or
2416 agency title insurance producer may not pay, allow, give, or offer to pay, allow, or give,
2417 directly or indirectly, as an inducement to obtaining any title insurance business:

2418 (i) any rebate, reduction, or abatement of any rate or charge made incident to the
2419 issuance of the title insurance;

2420 (ii) any special favor or advantage not generally available to others;

2421 (iii) any money or other consideration, except if approved under Section 31A-2-405; or

2422 (iv) material inducement.

2423 (b) "Charge made incident to the issuance of the title insurance" includes escrow
2424 charges, and any other services that are prescribed in rule by the Title and Escrow Commission
2425 after consultation with the commissioner and subject to Section 31A-2-404.

2426 (c) An insured or any other person connected, directly or indirectly, with the
2427 transaction may not knowingly receive or accept, directly or indirectly, any benefit referred to
2428 in Subsection (2)(a), including:

2429 (i) a person licensed under Title 61, Chapter 2c, Utah Residential Mortgage Practices
2430 and Licensing Act;

2431 (ii) a person licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices
2432 Act;

2433 (iii) a builder;

2434 (iv) an attorney; or

2435 (v) an officer, employee, or agent of a person listed in this Subsection (2)(c)(iii).

2436 (3) (a) An insurer may not unfairly discriminate among policyholders by charging
2437 different premiums or by offering different terms of coverage, except on the basis of
2438 classifications related to the nature and the degree of the risk covered or the expenses involved.

2439 (b) Rates are not unfairly discriminatory if they are averaged broadly among persons
2440 insured under a group, blanket, or franchise policy, and the terms of those policies are not
2441 unfairly discriminatory merely because they are more favorable than in similar individual
2442 policies.

2443 (4) (a) This Subsection (4) applies to:

2444 (i) a person who is or should be licensed under this title;

2445 (ii) an employee of that licensee or person who should be licensed;

2446 (iii) a person whose primary interest is as a competitor of a person licensed under this
2447 title; and

2448 (iv) one acting on behalf of any person described in Subsections (4)(a)(i) through (iii).

2449 (b) A person described in Subsection (4)(a) may not commit or enter into any
2450 agreement to participate in any act of boycott, coercion, or intimidation that:

2451 (i) tends to produce:

2452 (A) an unreasonable restraint of the business of insurance; or

2453 (B) a monopoly in that business; or

2454 (ii) results in an applicant purchasing or replacing an insurance contract.

2455 (5) (a) (i) Subject to Subsection (5)(a)(ii), a person may not restrict in the choice of an
2456 insurer or licensee under this chapter, another person who is required to pay for insurance as a
2457 condition for the conclusion of a contract or other transaction or for the exercise of any right
2458 under a contract.

2459 (ii) A person requiring coverage may reserve the right to disapprove the insurer or the
2460 coverage selected on reasonable grounds.

2461 (b) The form of corporate organization of an insurer authorized to do business in this
2462 state is not a reasonable ground for disapproval, and the commissioner may by rule specify
2463 additional grounds that are not reasonable. This Subsection (5) does not bar an insurer from
2464 declining an application for insurance.

2465 (6) A person may not make any charge other than insurance premiums and premium
2466 financing charges for the protection of property or of a security interest in property, as a
2467 condition for obtaining, renewing, or continuing the financing of a purchase of the property or
2468 the lending of money on the security of an interest in the property.

2469 (7) (a) A licensee under this title may not refuse or fail to return promptly all indicia of
2470 agency to the principal on demand.

2471 (b) A licensee whose license is suspended, limited, or revoked under Section
2472 [31A-2-308](#), [31A-23a-111](#), or [31A-23a-112](#) may not refuse or fail to return the license to the
2473 commissioner on demand.

2474 (8) (a) A person may not engage in an unfair method of competition or any other unfair
2475 or deceptive act or practice in the business of insurance, as defined by the commissioner by
2476 rule, after a finding that the method of competition, the act, or the practice:

- 2477 (i) is misleading;
- 2478 (ii) is deceptive;
- 2479 (iii) is unfairly discriminatory;
- 2480 (iv) provides an unfair inducement; or
- 2481 (v) unreasonably restrains competition.

2482 (b) Notwithstanding Subsection (8)(a), for purpose of the title insurance industry, the
 2483 Title and Escrow Commission shall make rules, subject to Section 31A-2-404, that define an
 2484 unfair method of competition or unfair or deceptive act or practice after a finding that the
 2485 method of competition, the act, or the practice:

- 2486 (i) is misleading;
- 2487 (ii) is deceptive;
- 2488 (iii) is unfairly discriminatory;
- 2489 (iv) provides an unfair inducement; or
- 2490 (v) unreasonably restrains competition.

2491 Section 21. Section 31A-30-102 is amended to read:

2492 **31A-30-102. Purpose statement.**

2493 The purpose of this chapter is to:

- 2494 (1) prevent abusive rating practices;
- 2495 (2) require disclosure of rating practices to purchasers;
- 2496 (3) establish rules regarding:
 - 2497 (a) a universal individual and small group application; and
 - 2498 (b) renewability of coverage;
- 2499 (4) improve the overall fairness and efficiency of the individual and small group
 2500 insurance market; and
- 2501 (5) provide increased access for individuals and small employers to health insurance[;
- 2502 and].

2503 [~~(6) provide an employer with the opportunity to establish a defined contribution~~
 2504 ~~arrangement for an employee to purchase a health benefit plan through the Health Insurance~~
 2505 ~~Exchange created by Section 63N-11-104.]~~

2506 Section 22. Section 31A-30-104 is amended to read:

2507 **31A-30-104. Applicability and scope.**

- 2508 (1) This chapter applies to any:
- 2509 (a) health benefit plan that provides coverage to:
- 2510 (i) individuals;
- 2511 (ii) small employers, except as provided in Subsection (3); or
- 2512 (iii) both Subsections (1)(a)(i) and (ii); or
- 2513 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
- 2514 31A-30-107.5.
- 2515 (2) This chapter applies to a health benefit plan that provides coverage to small
- 2516 employers or individuals regardless of:
- 2517 (a) whether the contract is issued to:
- 2518 (i) an association, except as provided in Subsection (3);
- 2519 (ii) a trust;
- 2520 (iii) a discretionary group; or
- 2521 (iv) other similar grouping; or
- 2522 (b) the situs of delivery of the policy or contract.
- 2523 (3) This chapter does not apply to:
- 2524 (a) short-term limited duration health insurance;
- 2525 (b) federally funded or partially funded programs; or
- 2526 (c) a bona fide employer association.
- 2527 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:
- 2528 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
- 2529 return shall be treated as one carrier; and
- 2530 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
- 2531 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
- 2532 carriers were issued by one carrier.
- 2533 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
- 2534 maintenance organization having a certificate of authority under this title may be considered to
- 2535 be a separate carrier for the purposes of this chapter.
- 2536 (c) Unless otherwise authorized by the commissioner [~~or by Chapter 42, Defined~~
- 2537 ~~Contribution Risk Adjuster Act~~], a covered carrier may not enter into one or more ceding
- 2538 arrangements with respect to health benefit plans delivered or issued for delivery to covered

2539 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
2540 obligation or risk for the health benefit plans being retained by the ceding carrier.

2541 (d) Section [31A-22-1201](#) applies if a covered carrier cedes or assumes all of the
2542 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
2543 for delivery to covered insureds in this state.

2544 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
2545 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
2546 may make a written request to the commissioner for a waiver from the application of any of the
2547 provisions of Subsections [31A-30-106\(1\)](#) and [31A-30-106.1\(1\)](#) with respect to a health benefit
2548 plan provided to the trust.

2549 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
2550 waiver if the commissioner finds that application with respect to the trust would:

2551 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
2552 and

2553 (ii) require significant modifications to one or more collective bargaining arrangements
2554 under which the trust is established or maintained.

2555 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
2556 person participates in a Taft Hartley trust as an associate member of any employee
2557 organization.

2558 (6) Sections [31A-22-618.6](#), [31A-30-106](#), [31A-30-106.1](#), [31A-30-106.5](#), [31A-30-106.7](#),
2559 [~~[31A-30-107](#)~~], and [31A-30-108](#), apply to:

2560 (a) any insurer engaging in the business of insurance related to the risk of a small
2561 employer for medical, surgical, hospital, or ancillary health care expenses of the small
2562 employer's employees provided as an employee benefit; and

2563 (b) any contract of an insurer, other than a workers' compensation policy, related to the
2564 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the
2565 small employer's employees provided as an employee benefit.

2566 (7) The commissioner may make rules requiring that the marketing practices be
2567 consistent with this chapter for:

2568 (a) a small employer carrier;

2569 (b) a small employer carrier's agent;

- 2570 (c) an insurance producer;
- 2571 (d) an insurance consultant; and
- 2572 (e) a navigator.

2573 Section 23. Section **31A-30-106.7** is amended to read:

2574 **31A-30-106.7. Surcharge for groups changing carriers.**

2575 (1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered
2576 carrier may impose upon a small group that changes coverage to that carrier from another
2577 carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could
2578 otherwise charge under Section [31A-30-106.1](#).

2579 (b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

- 2580 (i) the change in carriers occurs on the anniversary of the plan year, as defined in
2581 Section [31A-1-301](#);
- 2582 (ii) the previous coverage was terminated under Subsection [~~31A-30-107(3)(e)~~]
2583 [31A-22-618.6\(5\)](#);

- 2584 (iii) employees from an existing group form a new business; and
- 2585 (iv) the surcharge is not applied uniformly to all similarly situated small groups.

2586 (2) A covered carrier may not impose the surcharge described in Subsection (1) if the
2587 offer to cover the group occurs at a time other than the anniversary of the plan year because:

- 2588 (a) (i) the application for coverage is made prior to the anniversary date in accordance
2589 with the covered carrier's published policies; and
- 2590 (ii) the offer to cover the group is not issued until after the anniversary date; or
- 2591 (b) (i) the application for coverage is made prior to the anniversary date in accordance
2592 with the covered carrier's published policies; and
- 2593 (ii) additional underwriting or rating information requested by the covered carrier is not
2594 received until after the anniversary date.

2595 (3) If a covered carrier chooses to apply a surcharge under Subsection (1), the
2596 application of the surcharge and the criteria for incurring or avoiding the surcharge shall be
2597 clearly stated in the:

- 2598 (a) written application materials provided to the applicant at the time of application;
- 2599 and
- 2600 (b) written producer guidelines.

2601 (4) The commissioner shall adopt rules in accordance with Title 63G, Chapter 3, Utah
2602 Administrative Rulemaking Act, to ensure compliance with this section.

2603 Section 24. Section **31A-30-204** is amended to read:

2604 **31A-30-204. Employer election -- Defined benefit -- Defined contribution**
2605 **arrangements -- Responsibilities.**

2606 (1) (a) An employer participating in the defined contribution arrangement market on
2607 the Health Insurance Exchange shall make an initial election to offer its employees either a
2608 defined benefit plan or a defined contribution arrangement health benefit plan.

2609 (b) If an employer elects to offer a defined benefit plan:

2610 (i) the employer or the employer's producer shall enroll the employer in the Health
2611 Insurance Exchange;

2612 (ii) the employees shall submit the uniform application required for the Health
2613 Insurance Exchange; and

2614 (iii) the employer shall select the defined benefit plan in accordance with Section
2615 [31A-30-208](#).

2616 (c) When an employer makes an election under Subsections (1)(a) and (b):

2617 (i) the employer may not offer its employees a defined contribution arrangement health
2618 benefit plan; and

2619 (ii) the employees may not select a defined contribution arrangement health benefit
2620 plan in the Health Insurance Exchange.

2621 (d) If an employer elects to offer its employees a defined contribution arrangement
2622 health benefit plan, the employer shall comply with the provisions of Subsections (2) through
2623 (5).

2624 (2) (a) (i) An employer that chooses to participate in a defined contribution
2625 arrangement health benefit plan may not offer to an employee a health benefit plan that is not a
2626 defined contribution arrangement health benefit plan in the Health Insurance Exchange.

2627 (ii) Subsection (2)(a)(i) does not prohibit the offer of supplemental or limited benefit
2628 policies such as dental or vision coverage, or other types of federally qualified savings accounts
2629 for health care expenses.

2630 (b) (i) To the extent permitted by Sections [31A-1-301](#), [31A-30-112](#), and [31A-30-206](#),
2631 and the risk adjustment plan adopted under Section [31A-42-204](#), the employer reserves the

2632 right to determine:

2633 (A) the criteria for employee eligibility, enrollment, and participation in the employer's
2634 health benefit plan; and

2635 (B) the amount of the employer's contribution to that plan.

2636 (ii) The determinations made under Subsection (2)(b) may only be changed during
2637 periods of open enrollment.

2638 (3) An employer that chooses to establish a defined contribution arrangement health
2639 benefit plan to provide a health benefit plan for its employees shall:

2640 (a) establish a mechanism for its employees to use pre-tax dollars to purchase a health
2641 benefit plan from the defined contribution arrangement market on the [~~Health Insurance~~
2642 ~~Exchange created in Section 63N-11-104~~] small employer health insurance exchange known as
2643 Avenue H, which may include:

2644 (i) a health reimbursement arrangement;

2645 (ii) a Section 125 Cafeteria plan; or

2646 (iii) another plan or arrangement similar to Subsection (3)(a)(i) or (ii) which is
2647 excluded or deducted from gross income under the Internal Revenue Code;

2648 (b) before the employee's health benefit plan selection period:

2649 (i) inform each employee of the health benefit plan the employer has selected as the
2650 default health benefit plan for the employer group;

2651 (ii) offer each employee a choice of any of the defined contribution arrangement health
2652 benefit plans available through the defined contribution arrangement market on the Health
2653 Insurance Exchange; and

2654 (iii) notify the employee that the employee will be enrolled in the default health benefit
2655 plan selected by the employer and payroll deductions initiated for premium payments, unless
2656 the employee, before the employee's selection period ends:

2657 (A) selects a different defined contribution arrangement health benefit plan available in
2658 the Health Insurance Exchange;

2659 (B) provides proof of coverage from another health benefit plan; or

2660 (C) specifically declines coverage in a health benefit plan.

2661 (4) An employer shall enroll an employee in the default defined contribution

2662 arrangement health benefit plan selected by the employer if the employee does not make one of

2663 the choices described in Subsection (3)(b)(iii) before the end of the employee selection period,
2664 which may not be less than 14 calendar days.

2665 (5) The employer's notice to the employee under Subsection (3)(b)(iii) shall inform the
2666 employee that the failure to act under Subsections (3)(b)(iii)(A) through (C) is considered an
2667 affirmative election under pre-tax payroll deductions for the employer to begin payroll
2668 deductions for health benefit plan premiums.

2669 Section 25. Section **31A-34-110** is amended to read:

2670 **31A-34-110. Contracts with member employers and contracted insurers.**

2671 (1) Contracts between an alliance and members shall provide that the alliance is the
2672 contract holder of the health benefit plan policy on behalf of members and enrollees.

2673 (2) Contracts between an alliance and a contracted insurer shall specify how premiums
2674 will be transferred, what penalties and grace periods will be, and how examination costs will be
2675 allocated to contracted insurers.

2676 [~~(3) Subject only to Sections [31A-8-105.5](#) and [31A-8-501](#), and until July 1, 2004,
2677 health benefit plans offered exclusively in an alliance under this chapter may limit
2678 reimbursement to providers on the panel of a contracted insurer if the commissioner finds that
2679 the aggregate of alliance contracts available to its members provide a broad and substantial
2680 choice of providers, encompassing the vast majority of doctors and hospitals in the state.]~~

2681 Section 26. Section **31A-45-101** is enacted to read:

2682 **CHAPTER 45. MANAGED CARE ORGANIZATIONS**

2683 **Part 1. General Provisions**

2684 **31A-45-101. Title.**

2685 This chapter is known as "Managed Care Organizations."

2686 Section 27. Section **31A-45-102** is enacted to read:

2687 **31A-45-102. Definitions.**

2688 As used in this chapter:

2689 (1) "Covered benefit" or "benefit" means the health care services to which a covered
2690 person is entitled under the terms of a health benefit plan.

2691 (2) "Managed care organization" means:

2692 (a) a managed care organization as that term is defined in Section [31A-1-103](#); and

2693 (b) a third party administrator as that term is defined in Section [31A-1-103](#).

2694 Section 28. Section 31A-45-103 is enacted to read:

2695 **31A-45-103. Managed care contract standards.**

2696 The commissioner shall adopt rules relating to standards for the manner and content of
2697 policy provisions, and disclosures to be made in connection with the sale of policies covered by
2698 this chapter, dealing with at least the following matters:

- 2699 (1) terms of renewability;
- 2700 (2) initial and subsequent conditions of eligibility;
- 2701 (3) nonduplication of coverage provisions;
- 2702 (4) coverage of dependents;
- 2703 (5) termination of insurance;
- 2704 (6) limitations;
- 2705 (7) exceptions;
- 2706 (8) reductions;
- 2707 (9) definition of terms; and
- 2708 (10) rating practices.

2709 Section 29. Section 31A-45-201 is enacted to read:

2710 **Part 2. Applicability to Other Provisions of Law**

2711 **31A-45-201. Applicability to other provisions of law -- Commissioner discretion.**

- 2712 (1) Except for exemptions specifically granted under this title, a managed care
2713 organization is subject to regulation under all of the provisions of this title.
- 2714 (2) The commissioner may by rule waive other specific provisions of this title that the
2715 commissioner considers inapplicable to managed care organizations, upon a finding that the
2716 waiver will not endanger the interests of:

- 2717 (a) enrollees;
- 2718 (b) investors;
- 2719 (c) the public; or
- 2720 (d) health care providers.

2721 Section 30. Section 31A-45-301 is enacted to read:

2722 **Part 3. Relationships with Providers**

2723 **31A-45-301. Written contracts -- Limited liability of enrollee -- Provider claim**
2724 **disputes -- Leased networks.**

2725 (1) A managed care organization may not contract with a health care provider for
2726 treatment of illness or injury unless the health care provider is licensed to perform that
2727 treatment. Every contract between a managed care organization and a network provider shall be
2728 in writing and shall set forth that if the managed care organization:

2729 (a) fails to pay for health care services as set forth in the contract, the enrollee is not
2730 liable to the health care provider for any sums owed by the managed care organization; and

2731 (b) becomes insolvent, the rehabilitator or liquidator may require the network provider
2732 to:

2733 (i) continue to provide health care services under the contract between the network
2734 provider and the managed care organization until the earlier of:

2735 (A) 90 days after the date of the filing of a petition for rehabilitation or a petition for
2736 liquidation; or

2737 (B) the date the term of the contract ends; and

2738 (ii) subject to Subsection (3), reduce the fees the network provider is otherwise entitled
2739 to receive from the managed care organization under the contract between the network provider
2740 and the managed care organization during the time period described in Subsection (1)(b)(i).

2741 (2) If the conditions of Subsection (3) are met, the network provider:

2742 (a) shall accept the reduced payment as payment in full; and

2743 (b) as provided in Subsection (1)(a), may not collect additional amounts from the
2744 insolvent managed care organization's enrollee, except as may be owed under Subsection
2745 (3)(b).

2746 (3) Notwithstanding Subsection (1)(b)(ii):

2747 (a) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular
2748 fee set forth in the network provider contract; and

2749 (b) the enrollee shall continue to pay the same copayments, deductibles, and other
2750 payments for services received from the network provider that the enrollee was required to pay
2751 before the filing of:

2752 (i) the petition for rehabilitation; or

2753 (ii) the petition for liquidation.

2754 (4) A network provider may not collect or attempt to collect from the enrollee sums
2755 owed by the managed care organization or the amount of the regular fee reduction authorized

2756 under Subsection (1)(b)(ii) if the network provider contract:

2757 (a) is not in writing as required in Subsection (1); or

2758 (b) fails to contain the language required by Subsection (1).

2759 (5) (a) A person listed in Subsection (5)(b) may not bill or maintain any action at law

2760 against an enrollee to collect:

2761 (i) sums owed by the organization; or

2762 (ii) the amount of the regular fee reduction authorized under Subsection (1)(b)(ii).

2763 (b) Subsection (5)(a) applies to:

2764 (i) a network provider;

2765 (ii) an agent;

2766 (iii) a trustee; or

2767 (iv) an assignee of a person described in Subsections (5)(b)(i) through (iii).

2768 (c) In any dispute involving a network provider's claim for reimbursement, the network

2769 provider's claim shall be determined in accordance with applicable law, the network provider

2770 contract, the enrollee contract, and the managed care organization's written payment policies in

2771 effect at the time services were rendered.

2772 (d) If the parties are unable to resolve their dispute, the matter shall be subject to

2773 binding arbitration by a jointly selected arbitrator. Each party shall bear its own expense except

2774 that the cost of the jointly selected arbitrator shall be equally shared. This Subsection (5)(d)

2775 does not apply to the claim of a general acute hospital to the extent the claim is inconsistent

2776 with the hospital's provider agreement.

2777 (e) A managed care organization may not penalize a network provider solely for

2778 pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

2779 (6) If a managed care organization permits another private entity with which the

2780 managed care organization does not share common ownership or control to use or otherwise

2781 lease one or more of the organization's networks that include network providers, the managed

2782 care organization shall ensure, at a minimum, that the entity pays the network providers

2783 included in the managed care organization's network in accordance with the same fee schedule

2784 and general payment policies as the managed care organization would pay for those network

2785 providers, unless payment for services is governed by a public program's fee schedule.

2786 Section 31. Section **31A-45-302** is enacted to read:

2787 **31A-45-302. Provider payment information -- Notice of admissions.**

2788 (1) (a) A managed care organization shall provide the managed care organization's
 2789 network providers access to current information necessary for the network provider to
 2790 determine:

2791 (i) the effect of procedure codes on payment or compensation before a claim is
 2792 submitted for a procedure;

2793 (ii) the plans and carrier networks that the network provider is subject to as part of the
 2794 contract with the managed care organization; and

2795 (iii) in accordance with Subsection 31A-26-301.6(10)(f), the specific rate and terms
 2796 under which the network provider will be paid for health care services.

2797 (b) The information required by Subsection (1)(a) may be provided through a website,
 2798 and if requested by the network provider, notice of the updated website shall be provided by
 2799 the managed care organization.

2800 (2) (a) A managed care organization may not require a health care provider by contract,
 2801 reimbursement procedure, or otherwise to notify the managed care organization of a hospital
 2802 inpatient emergency admission within a period of time that is less than one business day of the
 2803 hospital inpatient admission, if compliance with the notification requirement would result in
 2804 notification by the health care provider on a weekend or federal holiday.

2805 (b) Subsection (2)(a) does not prohibit the applicability or administration of other
 2806 contract provisions between a managed care organization and a network provider that require
 2807 preauthorization for scheduled inpatient admissions.

2808 Section 32. Section **31A-45-303**, which is renumbered from Section 31A-22-617 is
 2809 renumbered and amended to read:

2810 ~~[31A-22-617].~~ **31A-45-303. Network provider contract provisions.**

2811 ~~[Health insurance policies]~~

2812 (1) Managed care organizations may provide for ~~[insureds]~~ enrollees to receive
 2813 services or reimbursement under the ~~[policies]~~ health benefit plans in accordance with
 2814 ~~[preferred health care provider contracts as follows:]~~ this section.

2815 ~~[(+)]~~ (2) (a) Subject to restrictions under this section, ~~[an insurer or third party~~
 2816 administrator] a managed care organization may enter into contracts with health care providers
 2817 ~~[as defined in Section 78B-3-403]~~ under which the health care providers agree to be a network

2818 provider and supply services, at prices specified in the contracts, to [persons insured by an
2819 insurer] enrollees.

2820 ~~[(a)(i) A health care]~~ (b) A network provider contract ~~[may]~~ shall require the ~~[health~~
2821 care] network provider to accept the specified payment in this Subsection ~~[(1)]~~ (2) as payment
2822 in full, relinquishing the right to collect ~~[additional]~~ amounts other than copayments,
2823 coinsurance, and deductibles from the ~~[insured person]~~ enrollee.

2824 ~~[(ii) In a dispute involving a provider's claim for reimbursement, the same shall be~~
2825 ~~determined in accordance with applicable law, the provider contract, the subscriber contract,~~
2826 ~~and the insurer's written payment policies in effect at the time services were rendered.]~~

2827 ~~[(iii) If the parties are unable to resolve their dispute, the matter shall be subject to~~
2828 ~~binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except~~
2829 ~~the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii)~~
2830 ~~does not apply to the claim of a general acute hospital to the extent it is inconsistent with the~~
2831 ~~hospital's provider agreement.]~~

2832 ~~[(iv) An organization may not penalize a provider solely for pursuing a claims dispute~~
2833 ~~or otherwise demanding payment for a sum believed owing.]~~

2834 ~~[(v) If an insurer permits another entity with which it does not share common~~
2835 ~~ownership or control to use or otherwise lease one or more of the organization's networks of~~
2836 ~~participating providers, the organization shall ensure, at a minimum, that the entity pays~~
2837 ~~participating providers in accordance with the same fee schedule and general payment policies~~
2838 ~~as the organization would for that network.]~~

2839 ~~[(b)]~~ (c) The insurance contract may reward the ~~[insured]~~ enrollee for selection of
2840 [preferred health care] network providers by:

- 2841 (i) reducing premium rates;
- 2842 (ii) reducing deductibles;
- 2843 (iii) coinsurance;
- 2844 (iv) other copayments; or
- 2845 (v) any other reasonable manner.

2846 ~~[(c) If the insurer is a managed care organization, as defined in Subsection~~
2847 ~~31A-27a-403(1)(f):]~~

2848 ~~[(i) the insurance contract and the health care provider contract shall provide that in the~~

2849 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:]

2850 ~~[(A) require the health care provider to continue to provide health care services under~~
2851 ~~the contract until the earlier of:]~~

2852 ~~[(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for~~
2853 ~~liquidation; or]~~

2854 ~~[(H) the date the term of the contract ends; and]~~

2855 ~~[(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled~~
2856 ~~to receive from the managed care organization during the time period described in Subsection~~
2857 ~~(1)(c)(i)(A);]~~

2858 ~~[(ii) the provider is required to:]~~

2859 ~~[(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and]~~

2860 ~~[(B) relinquish the right to collect additional amounts from the insolvent managed care~~
2861 ~~organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);]~~

2862 ~~[(iii) if the contract between the health care provider and the managed care~~
2863 ~~organization has not been reduced to writing, or the contract fails to contain the requirements~~
2864 ~~described in Subsection (1)(c)(i), the provider may not collect or attempt to collect from the~~
2865 ~~enrollee:]~~

2866 ~~[(A) sums owed by the insolvent managed care organization; or]~~

2867 ~~[(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);]~~

2868 ~~[(iv) the following may not bill or maintain an action at law against an enrollee to~~
2869 ~~collect sums owed by the insolvent managed care organization or the amount of the regular fee~~
2870 ~~reduction authorized under Subsection (1)(c)(i)(B):]~~

2871 ~~[(A) a provider;]~~

2872 ~~[(B) an agent;]~~

2873 ~~[(C) a trustee; or]~~

2874 ~~[(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and]~~

2875 ~~[(v) notwithstanding Subsection (1)(c)(i):]~~

2876 ~~[(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the~~
2877 ~~provider's regular fee set forth in the contract; and]~~

2878 ~~[(B) the enrollee shall continue to pay the copayments, deductibles, and other payments~~
2879 ~~for services received from the provider that the enrollee was required to pay before the filing~~

2880 of:]

2881 [~~(F) a petition for rehabilitation; or~~]

2882 [~~(H) a petition for liquidation.~~]

2883 [~~(2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health~~

2884 ~~care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on~~

2885 ~~or after January 1, 2014.~~]

2886 [~~(b)~~] (3) (a) When reimbursing for services of health care providers [~~not under contract,~~

2887 ~~the insurer may~~] that are not network providers, the managed care organization may:

2888 (i) make direct payment to the [insured:] enrollee; and

2889 [~~(c) An insurer using preferred health care provider contracts may~~]

2890 (ii) impose a deductible on coverage of health care providers not under contract.

2891 (b) (i) Subsections (3)(b)(iii) and (c) apply to a managed care organization licensed

2892 under:

2893 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

2894 (B) Chapter 7, Nonprofit Health Service Insurance Corporations; or

2895 (C) Chapter 14, Foreign Insurers; and

2896 (ii) Subsections (3)(b)(iii) and (c) and Subsection (6)(b) do not apply to a managed care

2897 organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health

2898 Plans.

2899 [~~(d)~~] (iii) When selecting health care providers with whom to contract under

2900 Subsection [~~(1), an insurer~~] (2), a managed care organization described in Subsection (3)(b)(i)

2901 may not unfairly discriminate between classes of health care providers, but may discriminate

2902 within a class of health care providers, subject to Subsection [~~(7)~~] (6).

2903 [~~(e)~~] (c) For purposes of this section, unfair discrimination between classes of health

2904 care providers includes:

2905 (i) refusal to contract with class members in reasonable proportion to the number of

2906 insureds covered by the insurer and the expected demand for services from class members; and

2907 (ii) refusal to cover procedures for one class of providers that are:

2908 (A) commonly used by members of the class of health care providers for the treatment

2909 of illnesses, injuries, or conditions;

2910 (B) otherwise covered by the [insurer] managed care organization; and

2911 (C) within the scope of practice of the class of health care providers.

2912 ~~[(3)]~~ (4) Before the ~~[insured]~~ enrollee consents to the insurance contract, the ~~[insurer]~~
 2913 managed care organization shall fully disclose to the ~~[insured that it]~~ enrollee that the managed
 2914 care organization has entered into ~~[preferred health care]~~ network provider contracts. The
 2915 ~~[insurer]~~ managed care organization shall provide sufficient detail on the ~~[preferred health~~
 2916 care] network provider contracts to permit the ~~[insured]~~ enrollee to agree to the terms of the
 2917 insurance contract. The ~~[insurer]~~ managed care organization shall provide at least the
 2918 following information:

2919 (a) a list of the health care providers under contract, and if requested their business
 2920 locations and specialties;

2921 (b) a description of the insured benefits, including deductibles, coinsurance, or other
 2922 copayments;

2923 (c) a description of the quality assurance program required under Subsection ~~[(4)]~~ (5);
 2924 and

2925 (d) a description of the adverse benefit determination procedures required under
 2926 ~~[Subsection (5)]~~ Section 31A-22-629.

2927 ~~[(4) (a) An insurer using preferred health care]~~

2928 (5) (a) A managed care organization using network provider contracts shall maintain a
 2929 quality assurance program for assuring that the care provided by the ~~[health care providers~~
 2930 under contract] network providers meets prevailing standards in the state.

2931 (b) The commissioner in consultation with the executive director of the Department of
 2932 Health may designate qualified persons to perform an audit of the quality assurance program.
 2933 The auditors shall have full access to all records of the managed care organization and ~~[its]~~ the
 2934 managed care organization's health care providers, including medical records of individual
 2935 patients.

2936 (c) The information contained in the medical records of individual patients shall
 2937 remain confidential. All information, interviews, reports, statements, memoranda, or other data
 2938 furnished for purposes of the audit and any findings or conclusions of the auditors are
 2939 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
 2940 proceeding except hearings before the commissioner concerning alleged violations of this
 2941 section.

2942 ~~[(5) An insurer using preferred health care provider contracts shall provide a~~
 2943 ~~reasonable procedure for resolving complaints and adverse benefit determinations initiated by~~
 2944 ~~the insureds and health care providers.]~~

2945 ~~[(6) An insurer may not contract with a health care provider for treatment of illness or~~
 2946 ~~injury unless the health care provider is licensed to perform that treatment.]~~

2947 ~~[(7)]~~ (6) (a) A health care provider or [insurer] managed care organization may not
 2948 discriminate against a [~~preferred health care~~] network provider for agreeing to a contract under
 2949 Subsection [(+)] (2).

2950 (b) (i) ~~Ĥ→ [This Subsection (6)(b) applies]~~ Subsections (6)(b) and (c) apply ~~←Ĥ~~ to a
 2950a managed care organization that is described
 2951 in Subsection (3)(b)(i) and Ĥ→ [does] do ←Ĥ not apply to a managed care organization described
 2951a in
 2952 Subsection (3)(b)(ii).

2953 (ii) A health care provider licensed to treat an illness or injury within the scope of the
 2954 health care provider's practice, [~~who~~] that is willing and able to meet the terms and conditions
 2955 established by the [insurer] managed care organization for designation as a [~~preferred health~~
 2956 ~~care~~] network provider, shall be able to apply for and receive the designation as a [~~preferred~~
 2957 ~~health care~~] network provider. Contract terms and conditions may include reasonable
 2958 limitations on the number of designated [~~preferred health care~~] network providers based upon
 2959 substantial objective and economic grounds, or expected use of particular services based upon
 2960 prior provider-patient profiles.

2961 ~~[(8)]~~ (c) Upon the written request of a provider excluded from a network provider
 2962 contract, the commissioner may hold a hearing to determine if the [insurer's] managed care
 2963 organization's exclusion of the provider is based on the criteria set forth in Subsection [(7)]
 2964 (6)(b).

2965 ~~[(9)]~~ (7) Nothing in this section is to be construed as to require [~~an insurer~~] a managed
 2966 care organization to offer a certain benefit or service as part of a health benefit plan.

2967 ~~[(10) This section does not apply to catastrophic mental health coverage provided in~~
 2968 ~~accordance with Section 31A-22-625.]~~

2969 ~~[(11)]~~ (8) Notwithstanding Subsection [(+);] (2) or Subsection [(7)] (6)(b), [~~and Section~~
 2970 31A-22-618, an insurer] a managed care organization described in Subsection (3)(b)(i) or third
 2971 party administrator is not required to, but may, enter into a contract with a licensed athletic
 2972 trainer, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

2973 Section 33. Section ~~31A-45-304~~, which is renumbered from Section 31A-22-617.1 is
2974 renumbered and amended to read:

2975 ~~[31A-22-617.1]~~. **31A-45-304. Objective criteria for adding or terminating**
2976 **participating providers -- Termination of contracts -- Review process.**

2977 (1) (a) [~~Every insurer, including a health maintenance organization governed by~~
2978 ~~Chapter 8, Health Maintenance Organizations and Limited Health Plans,]~~ A managed care
2979 organization shall establish criteria for adding health care providers to a new or existing
2980 network provider panel.

2981 (b) Criteria under Subsection (1)(a) may include~~[, but are not limited to]:~~

2982 (i) training, certification, and hospital privileges;

2983 (ii) number of [~~physicians~~] health care providers needed to adequately serve the
2984 [~~insurer's~~] managed care organization's population; and

2985 (iii) any other factor that is reasonably related to promote or protect good patient care,
2986 address costs, take into account on-call and cross-coverage relationships between providers, or
2987 serve the lawful interests of the [~~insurer~~] managed care organization.

2988 (c) [~~An insurer~~] A managed care organization shall make such criteria available to any
2989 provider upon request and shall file the same with the department.

2990 (d) Upon receipt of a provider application and upon receiving all necessary
2991 information, [~~an insurer~~] a managed care organization shall make a decision on a provider's
2992 application for participation within 120 days.

2993 (e) If the provider applicant is rejected, the [~~insurer~~] managed care organization shall
2994 inform the provider of the reason for the rejection relative to the criteria established in
2995 accordance with Subsection (1)(b).

2996 (f) [~~An insurer~~] A managed care organization may not reject a provider applicant based
2997 solely on:

2998 (i) the provider's staff privileges at a general acute care hospital not under contract with
2999 the [~~insurer~~] managed care organization; or

3000 (ii) the provider's referral patterns for patients who are not covered by the [~~insurer~~]
3001 managed care organization.

3002 (g) Criteria set out in Subsection (1)(b) may be modified or changed from time to time
3003 to meet the business needs of the market in which the [~~insurer~~] managed care organization

3004 operates and, if modified, will be filed with the department as provided in Subsection (1)(c).

3005 (h) With the exception of Subsection (1)(f), this section does not create any new or
3006 additional private right of action for redress.

3007 (2) (a) For the first two years, [~~an insurer~~] a managed care organization may terminate
3008 its contract with a provider with or without cause upon giving the requisite amount of notice
3009 provided in the agreement, but in no case shall it be less than 60 days.

3010 (b) An agreement may be terminated for cause as provided in the contract established
3011 between the [~~insurer~~] managed care organization and the provider. Such contract shall contain
3012 sufficiently certain criteria so that the provider can be reasonably informed of the grounds for
3013 termination for cause.

3014 (c) [~~Prior to~~] Before termination for cause, the [~~insurer shall~~] managed care
3015 organization:

3016 (i) shall inform the provider of the intent to terminate and the grounds for doing so;

3017 (ii) shall at the request of the provider, meet with the provider to discuss the reasons for
3018 termination;

3019 (iii) if the [~~insurer~~] managed care organization has a reasonable basis to believe that the
3020 provider may correct the conduct giving rise to the notice of termination, [~~the insurer~~] may, at
3021 its discretion, place the provider on probation with corrective action requirements, restrictions,
3022 or both, as necessary to protect patient care; and

3023 (iv) if the [~~insurer~~] managed care organization has a reasonable basis to believe that the
3024 provider has engaged in fraudulent conduct or poses a significant risk to patient care or safety,
3025 [~~the insurer~~] may immediately suspend the provider from further performance under the
3026 contract, provided that the remaining provisions of this Subsection (2) are followed in a timely
3027 manner before termination may become final.

3028 (d) Each [~~insurer~~] managed care organization shall establish an internal appeal process
3029 for actions that may result in terminated participation with cause and make known to the
3030 provider the procedure for appealing such termination.

3031 (i) Providers dissatisfied with the results of the appeal process may, if both parties
3032 agree, submit the matters in dispute to mediation.

3033 (ii) If the matters in dispute are not mediated, or should mediation be unsuccessful, the
3034 dispute shall be subject to binding arbitration by an arbitrator jointly selected by the parties, the

3035 cost of which shall be jointly shared. Each party shall bear its own additional expenses.

3036 (e) A termination under Subsection (2)(a) or (b) may not be based on:

3037 (i) the provider's staff privileges at a general acute care hospital not under contract with
3038 the ~~[insurer]~~ managed care organization; or

3039 (ii) the provider's referral patterns for patients who are not covered by the ~~[insurer]~~
3040 managed care organization.

3041 (3) Notwithstanding any other section of this title, ~~[an insurer]~~ a managed care
3042 organization may not take adverse action against or reduce reimbursement to a ~~[contracted]~~
3043 network provider who is not under a capitated reimbursement arrangement because of the
3044 decision of an ~~[insured]~~ enrollee to access health care services from a ~~[noncontracted]~~
3045 non-network provider in a manner permitted by the ~~[insured's]~~ enrollee's health insurance plan,
3046 regardless of how the plan is designated.

3047 Section 34. Section **31A-45-401**, which is renumbered from Section 31A-8-502 is
3048 renumbered and amended to read:

3049 **Part 4. Access To Services For Managed Care Enrollees**

3050 ~~[31A-8-502]~~. **31A-45-401. Court ordered coverage for minor children who**
3051 **reside outside the service area.**

3052 (1) (a) The requirements of Subsection (2) apply to a ~~[health maintenance organization~~
3053 ~~if the health maintenance organization plan]~~ managed care organization if the managed care
3054 organization health benefit plan:

3055 (i) restricts coverage for nonemergency services to services provided by contracted
3056 providers within the organization's service area; and

3057 (ii) does not offer a benefit that permits members the option of obtaining covered
3058 services from a ~~[non-contracted]~~ non-network provider.

3059 (b) The requirements of Subsection (2) do not apply to a ~~[health maintenance]~~
3060 managed care organization if:

3061 (i) the child that is the subject of a court or administrative support order is over the age
3062 of 18 and is no longer enrolled in high school; or

3063 (ii) a parent's employer offers the parent a choice to select health insurance coverage
3064 that is not a ~~[health maintenance]~~ managed care organization plan either at the time of the court
3065 or administrative support order, or at a subsequent open enrollment period. This exemption

3066 from Subsection (2) applies even if the parent ultimately chooses the [~~health maintenance~~]
3067 managed care organization plan.

3068 (2) If a parent is required by a court or administrative support order to provide health
3069 insurance coverage for a child who resides outside of a [~~health maintenance~~] managed care
3070 organization's service area, the [~~health maintenance~~] managed care organization shall:

3071 (a) comply with the provisions of Section 31A-22-610.5;

3072 (b) allow the enrollee parent to enroll the child on the organization plan;

3073 (c) pay for otherwise covered health care services rendered to the child outside of the
3074 service area by a [~~noncontracted~~] non-network provider:

3075 (i) if the child, noncustodial parent, or custodial parent has complied with prior
3076 authorization or utilization review otherwise required by the organization; and

3077 (ii) in an amount equal to the dollar amount the organization pays under a noncapitated
3078 arrangement for comparable services to a [~~contracting~~] network provider in the same class of
3079 health care providers as the provider who rendered the services; and

3080 (d) make payments on claims submitted in accordance with Subsection (2)(c) directly
3081 to the provider, custodial parent, the child who obtained benefits, or state Medicaid agency.

3082 (3) (a) The parents of the child who is the subject of the court or administrative support
3083 order are responsible for any charges billed by the provider in excess of those paid by the
3084 organization.

3085 (b) This section does not affect any court or administrative order regarding the
3086 responsibilities between the parents to pay any medical expenses not covered by accident and
3087 health insurance or a [~~health maintenance~~] managed care organization plan.

3088 (4) The commissioner shall adopt rules as necessary to administer this section and
3089 Section 31A-22-610.5.

3090 Section 35. Section 31A-45-402 is enacted to read:

3091 **31A-45-402. Alcohol and drug dependency treatment.**

3092 (1) A managed care organization offering a health benefit plan providing coverage for
3093 alcohol or drug dependency treatment may require an inpatient facility to be licensed by:

3094 (a) (i) the Department of Human Services, under Title 62A, Chapter 2, Licensure of
3095 Programs and Facilities; or

3096 (ii) the Department of Health; or

3097 (b) for an inpatient facility located outside the state, a state agency similar to one
 3098 described in Subsection (1)(a).

3099 (2) For inpatient coverage provided pursuant to Subsection (1), a managed care
 3100 organization may require an inpatient facility to be accredited by the following:

3101 (a) the Joint Commission; and

3102 (b) one other nationally recognized accrediting agency.

3103 Section 36. Section **31A-45-501**, which is renumbered from Section 31A-8-501 is
 3104 renumbered and amended to read:

Part 5. Network Adequacy

3106 ~~[31A-8-501].~~ **31A-45-501. Access to health care providers.**

3107 (1) As used in this section:

3108 (a) "Class of health care provider" means a health care provider or a health care facility
 3109 regulated by the state within the same professional, trade, occupational, or certification
 3110 category established under Title 58, Occupations and Professions, or within the same facility
 3111 licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and
 3112 Inspection Act.

3113 (b) "Covered health care services" or "covered services" means health care services for
 3114 which an enrollee is entitled to receive under the terms of a health maintenance organization
 3115 contract.

3116 (c) "Credentialed staff member" means a health care provider with active staff
 3117 privileges at an independent hospital or federally qualified health center.

3118 (d) "Federally qualified health center" means as defined in the Social Security Act, 42
 3119 U.S.C. Sec. 1395x.

3120 (e) "Independent hospital" means a general acute hospital or a critical access hospital
 3121 that:

3122 (i) is either:

3123 (A) located 20 miles or more from any other general acute hospital or critical access
 3124 hospital; or

3125 (B) licensed as of January 1, 2004;

3126 (ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and
 3127 Inspection Act; and

3128 (iii) is controlled by a board of directors of which 51% or more reside in the county
3129 where the hospital is located and:

3130 (A) the board of directors is ultimately responsible for the policy and financial
3131 decisions of the hospital; or

3132 (B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part,
3133 by an entity that owns or controls a health maintenance organization if the hospital is a
3134 contracting facility of the organization.

3135 (f) "Noncontracting provider" means an independent hospital, federally qualified health
3136 center, or credentialed staff member [~~who~~] that has not contracted with a [~~health maintenance~~]
3137 managed care organization to provide health care services to enrollees of the managed care
3138 organization.

3139 (2) Except for a [~~health maintenance~~] managed care organization [~~which~~] that is under
3140 the common ownership or control of an entity with a hospital located within 10 paved road
3141 miles of an independent hospital, a [~~health maintenance~~] managed care organization shall pay
3142 for covered health care services rendered to an enrollee by an independent hospital, a
3143 credentialed staff member at an independent hospital, or a credentialed staff member at his
3144 local practice location if:

3145 (a) the enrollee:

3146 (i) lives or resides within 30 paved road miles of the independent hospital; or

3147 (ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the
3148 independent hospital than a contracting hospital;

3149 (b) the independent hospital is located prior to December 31, 2000 in a county with a
3150 population density of less than 100 people per square mile, or the independent hospital is
3151 located in a county with a population density of less than 30 people per square mile; and

3152 (c) the enrollee has complied with the prior authorization and utilization review
3153 requirements otherwise required by the [~~health maintenance~~] managed care organization
3154 contract.

3155 (3) A [~~health maintenance~~] managed care organization shall pay for covered health care
3156 services rendered to an enrollee at a federally qualified health center if:

3157 (a) the enrollee:

3158 (i) lives or resides within 30 paved road miles of the federally qualified health center;

3159 or

3160 (ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the
3161 federally qualified health center than a contracting provider;

3162 (b) the federally qualified health center is located in a county with a population density
3163 of less than 30 people per square mile; and

3164 (c) the enrollee has complied with the prior authorization and utilization review
3165 requirements otherwise required by the ~~[health maintenance]~~ managed care organization
3166 contract.

3167 (4) (a) A ~~[health maintenance]~~ managed care organization shall reimburse a
3168 noncontracting provider or the enrollee for covered services rendered pursuant to Subsection
3169 (2) a like dollar amount as it pays to contracting providers under a noncapitated arrangement
3170 for comparable services.

3171 (b) A ~~[health maintenance]~~ managed care organization shall reimburse a federally
3172 qualified health center or the enrollee for covered services rendered pursuant to Subsection (3)
3173 a like amount as paid by the ~~[health maintenance]~~ managed care organization under a
3174 noncapitated arrangement for comparable services to a contracting provider in the same class
3175 of health care providers as the provider who rendered the service.

3176 (5) (a) A noncontracting independent hospital may not balance bill a patient when the
3177 health maintenance organization reimburses a noncontracting independent hospital or an
3178 enrollee in accordance with Subsection (4)(a).

3179 (b) A noncontracting federally qualified health center may not balance bill a patient
3180 when the federally qualified health center or the enrollee receives reimbursement in accordance
3181 with Subsection (4)(b).

3182 (6) A noncontracting provider may only refer an enrollee to another noncontracting
3183 provider so as to obligate the enrollee's ~~[health maintenance]~~ managed care organization to pay
3184 for the resulting services if:

3185 (a) the noncontracting provider making the referral or the enrollee has received prior
3186 authorization from the organization for the referral; or

3187 (b) the practice location of the noncontracting provider to whom the referral is made:
3188 (i) is located in a county with a population density of less than 25 people per square
3189 mile; and

3190 (ii) is within 30 paved road miles of:
3191 (A) the place where the enrollee lives or resides; or
3192 (B) the independent hospital or federally qualified health center at which the enrollee
3193 may receive covered services pursuant to Subsection (2) or (3).

3194 (7) Notwithstanding this section, a [~~health maintenance~~] managed care organization
3195 may contract directly with an independent hospital, federally qualified health center, or
3196 credentialed staff member.

3197 (8) (a) A [~~health maintenance~~] managed care organization that violates any provision
3198 of this section is subject to sanctions as determined by the commissioner in accordance with
3199 Section [31A-2-308](#).

3200 (b) Violations of this section include:

3201 (i) failing to provide the notice required by Subsection (8)(d) by placing the notice in
3202 any [~~health maintenance~~] managed care organization's provider list that is supplied to enrollees,
3203 including any website maintained by the [~~health maintenance~~] managed care organization;

3204 (ii) failing to provide notice of an enrollee's rights under this section when:

3205 (A) an enrollee makes personal contact with the [~~health maintenance~~] managed care
3206 organization by telephone, electronic transaction, or in person; and

3207 (B) the enrollee inquires about [~~his~~] the enrollee's rights to access an independent
3208 hospital or federally qualified health center; and

3209 (iii) refusing to reprocess or reconsider a claim, initially denied by the [~~health~~
3210 ~~maintenance~~] managed care organization, when the provisions of this section apply to the
3211 claim.

3212 (c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of
3213 Commissioner:

3214 (i) adopt rules as necessary to implement this section;

3215 (ii) identify in rule:

3216 (A) the counties with a population density of less than 100 people per square mile;

3217 (B) independent hospitals as defined in Subsection (1)(e); and

3218 (C) federally qualified health centers as defined in Subsection (1)(d).

3219 (d) (i) A [~~health maintenance~~] managed care organization shall:

3220 (A) use the information developed by the commissioner under Subsection (8)(c) to

3221 identify the rural counties, independent hospitals, and federally qualified health centers that are
 3222 located in the [~~health maintenance~~] managed care organization's service area; and

3223 (B) include the providers identified under Subsection (8)(d)(i)(A) in the notice required
 3224 in Subsection (8)(d)(ii).

3225 (ii) The [~~health maintenance~~] managed care organization shall provide the following
 3226 notice, in bold type, to enrollees as specified under Subsection (8)(b)(i), and shall keep the
 3227 notice current:

3228 "You may be entitled to coverage for health care services from the following
 3229 [~~non-HMO contracted~~] noncontracted providers if you live or reside within 30 paved road
 3230 miles of the listed providers, or if you live or reside in closer proximity to the listed providers
 3231 than to your [~~HMO~~] contracted providers:

3232 This list may change periodically, please check on our website or call for verification.
 3233 Please be advised that if you choose a noncontracted provider you will be responsible for any
 3234 charges not covered by your health insurance plan.

3235 If you have questions concerning your rights to see a provider on this list you may
 3236 contact your [~~health maintenance~~] managed care organization at _____. If the [~~HMO~~]
 3237 managed care organization does not resolve your problem, you may contact the Office of
 3238 Consumer Health Assistance in the Insurance Department, toll free."

3239 (e) A person whose interests are affected by an alleged violation of this section may
 3240 contact the Office of Consumer Health Assistance and request assistance, or file a complaint as
 3241 provided in Section [31A-2-216](#).

3242 Section 37. Section ~~49-20-407~~ is amended to read:

3243 **49-20-407. Insurance mandates.**

3244 Notwithstanding the provisions of Subsection [31A-1-103\(3\)\(f\)](#):

3245 (1) health coverage offered to the state employee risk pool under Subsection
 3246 [49-20-202\(1\)\(a\)](#) shall comply with the provisions of Sections [~~31A-8-501 and~~] [31A-22-605.5](#)
 3247 and ~~Ĥ~~ → [\[31A-45-303;\]](#) [31A-45-501](#) ← ~~Ĥ~~ and

3248 (2) a health plan offered to public school districts, charter schools, and institutions of
 3249 higher education under Subsection [49-20-201\(1\)\(b\)](#) shall comply with the provisions of Section
 3250 [31A-22-605.5](#).

3251 Section 38. Section ~~53-2a-1102~~ is amended to read:

3252 **53-2a-1102. Search and Rescue Financial Assistance Program -- Uses --**
3253 **Rulemaking -- Distribution.**

3254 (1) (a) "Assistance card program" means the Utah Search and Rescue Assistance Card
3255 Program created within this section.

3256 (b) "Card" means the Search and Rescue Assistance Card issued under this section to a
3257 participant.

3258 (c) "Participant" means an individual, family, or group who is registered pursuant to
3259 this section as having a valid card at the time search, rescue, or both are provided.

3260 (d) "Program" means the Search and Rescue Financial Assistance Program created
3261 within this section.

3262 (e) (i) "Reimbursable expenses," as used in this section, means those reasonable
3263 expenses incidental to search and rescue activities.

3264 (ii) "Reimbursable expenses" include:

3265 (A) rental for fixed wing aircraft, helicopters, snowmobiles, boats, and generators;

3266 (B) replacement and upgrade of search and rescue equipment;

3267 (C) training of search and rescue volunteers;

3268 (D) costs of providing workers' compensation benefits for volunteer search and rescue
3269 team members under Section [67-20-7.5](#); and

3270 (E) any other equipment or expenses necessary or appropriate for conducting search
3271 and rescue activities.

3272 (iii) "Reimbursable expenses" do not include any salary or overtime paid to any person
3273 on a regular or permanent payroll, including permanent part-time employees of any agency of
3274 the state.

3275 (f) "Rescue" means search services, rescue services, or both search and rescue services.

3276 (2) There is created the Search and Rescue Financial Assistance Program within the
3277 division.

3278 (3) (a) The program shall be funded from the following revenue sources:

3279 (i) any voluntary contributions to the state received for search and rescue operations;

3280 (ii) money received by the state under Subsection (11) and under Sections [23-19-42](#),
3281 [41-22-34](#), and [73-18-24](#); and

3282 (iii) appropriations made to the program by the Legislature.

3283 (b) All money received from the revenue sources in Subsections (3)(a)(i) and (ii) shall
3284 be deposited into the General Fund as a dedicated credit to be used solely for the purposes
3285 under this section.

3286 (c) All funding for the program is nonlapsing.

3287 (4) The director shall use the money to reimburse counties for all or a portion of each
3288 county's reimbursable expenses for search and rescue operations, subject to:

3289 (a) the approval of the Search and Rescue Advisory Board as provided in Section
3290 [53-2a-1104](#);

3291 (b) money available in the program; and

3292 (c) rules made under Subsection (7).

3293 (5) Program money may not be used to reimburse for any paid personnel costs or paid
3294 man hours spent in emergency response and search and rescue related activities.

3295 (6) The Legislature finds that these funds are for a general and statewide public
3296 purpose.

3297 (7) The division, with the approval of the Search and Rescue Advisory Board, shall
3298 make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and
3299 consistent with this section:

3300 (a) specifying the costs that qualify as reimbursable expenses;

3301 (b) defining the procedures of counties to submit expenses and be reimbursed;

3302 (c) defining a participant in the assistance card program, including:

3303 (i) individuals; and

3304 (ii) families and organized groups who qualify as participants;

3305 (d) defining the procedure for issuing a card to a participant;

3306 (e) defining excluded expenses that may not be reimbursed under the program,
3307 including medical expenses;

3308 (f) establishing the card renewal cycle for the Utah Search and Rescue Assistance Card
3309 Program;

3310 (g) establishing the frequency of review of the fee schedule;

3311 (h) providing for the administration of the program; and

3312 (i) providing a formula to govern the distribution of available money among the
3313 counties for uncompensated search and rescue expenses based on:

- 3314 (i) the total qualifying expenses submitted;
- 3315 (ii) the number of search and rescue incidents per county population;
- 3316 (iii) the number of victims that reside outside the county; and
- 3317 (iv) the number of volunteer hours spent in each county in emergency response and
- 3318 search and rescue related activities per county population.

3319 (8) (a) The division shall, in consultation with the Outdoor Recreation Office, establish
3320 the fee schedule of the Search and Rescue Assistance Card under Subsection 63J-1-504(6).

3321 (b) The division shall provide a discount of not less than 10% of the card fee under
3322 Subsection (8)(a) to a person who has paid a fee under Section 23-19-42, 41-22-34, or
3323 73-18-24 during the same calendar year in which the person applies to be a participant in the
3324 assistance card program.

3325 (9) (a) Counties may bill reimbursable expenses to an individual for costs incurred for
3326 the rescue of an individual, if the individual is not a participant in the Utah Search and Rescue
3327 Assistance Card Program.

3328 (b) Counties may bill a participant for reimbursable expenses for costs incurred for the
3329 rescue of the participant if the participant is found by the rescuing county to have acted
3330 recklessly or to have intentionally created a situation resulting in the need for a county to
3331 provide rescue service for the participant.

3332 (10) (a) There is created the Utah Search and Rescue Assistance Card Program. The
3333 program is located within the division.

3334 (b) The program may not be utilized to cover any expenses, such as medically related
3335 expenses, that are not reimbursable expenses related to the rescue.

3336 (11) (a) To participate in the program, a person shall purchase a Search and Rescue
3337 Assistance Card from the division by paying the fee as determined by the division in
3338 Subsection (8).

3339 (b) The money generated by the fees shall be deposited into the General Fund as a
3340 dedicated credit for the Search and Rescue Financial Assistance Program created in this
3341 section.

3342 (c) Participation and payment of fees by a person under Sections 23-19-42, 41-22-34,
3343 and 73-18-24 do not constitute purchase of a card under this section.

3344 (12) The division shall consult with the Outdoor Recreation Office regarding:

3345 (a) administration of the assistance card program; and

3346 (b) outreach and marketing strategies.

3347 (13) Pursuant to Subsection [31A-1-103](#)(7), the Utah Search and Rescue Assistance

3348 Card Program under this section is exempt from being considered ~~[an]~~ insurance ~~[program~~

3349 ~~under Subsection [31A-1-301](#)(86)]~~ as that term is defined in Section [31A-1-301](#).

3350 Section 39. Section **58-16a-601** is amended to read:

3351 **58-16a-601. Scope of practice.**

3352 (1) An optometrist may:

3353 (a) provide optometric services not specifically prohibited under this chapter or

3354 division rules if the services are within the optometrist's training, skills, and scope of

3355 competence; and

3356 (b) prescribe or administer pharmaceutical agents for the eye and its adnexa, including

3357 oral agents, subject to the following conditions:

3358 (i) an optometrist may prescribe oral antibiotics for only eyelid related ocular

3359 conditions or diseases, and other ocular conditions or diseases specified by division rule; and

3360 (ii) an optometrist may administer or prescribe a hydrocodone combination drug, or a

3361 Schedule III controlled substance, as defined in Section [58-37-4](#), only if:

3362 (A) the substance is administered or prescribed for pain of the eye or adnexa;

3363 (B) the substance is administered orally or topically or is prescribed for oral or topical

3364 use;

3365 (C) the amount of the substance administered or prescribed does not exceed a 72-hour

3366 quantity; and

3367 (D) if the substance is prescribed, the prescription does not include refills.

3368 (2) An optometrist may not:

3369 (a) perform surgery, including laser surgery; or

3370 (b) prescribe or administer a Schedule II controlled substance, as defined in Section

3371 [58-37-4](#), except for a hydrocodone combination drug, if so scheduled and prescribed or

3372 administered in accordance with Subsection (1)(b).

3373 (3) For purposes of Sections ~~[[31A-22-617](#) and]~~ [31A-22-618](#) and [31A-45-303](#), an

3374 optometrist is a health care provider.

3375 Section 40. Section **63I-2-231** is amended to read:

3376 **63I-2-231. Repeal dates, Title 31A.**

3377 (1) Section [31A-22-315.5](#) is repealed July 1, 2019.

3378 (2) Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements is repealed July
3379 1, 2019.

3380 (3) Title 31A, Chapter 30, Part 3, Individual and Small Employer Risk Adjustment Act
3381 is repealed July 1, 2019.

3382 ~~[(2)]~~ (4) Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed
3383 December 31, 2018.

3384 (5) Section [31A-45-503](#) is repealed July 1, 2022.

3385 Section 41. Section **63N-11-104** is amended to read:

3386 **63N-11-104. Creation of Office of Consumer Health Services -- Duties.**

3387 (1) There is created within the Governor's Office of Economic Development the Office
3388 of Consumer Health Services.

3389 (2) The ~~[consumer health office]~~ Office of Consumer Health Services shall:

3390 ~~[(a) in cooperation with the Insurance Department, the Department of Health, and the~~
3391 ~~Department of Workforce Services, and in accordance with the electronic standards developed~~
3392 ~~under Sections [31A-22-635](#) and [63N-11-107](#), create a Health Insurance Exchange that:]~~

3393 ~~[(i) provides information to consumers about private and public health programs for~~
3394 ~~which the consumer may qualify;]~~

3395 ~~[(ii) provides a consumer comparison of and enrollment in a health benefit plan posted~~
3396 ~~on the Health Insurance Exchange; and]~~

3397 ~~[(iii) includes information and a link to enrollment in premium assistance programs~~
3398 ~~and other government assistance programs;]~~

3399 ~~[(b) contract with one or more private vendors for:]~~

3400 ~~[(i) administration of the enrollment process on the Health Insurance Exchange,~~
3401 ~~including establishing a mechanism for consumers to compare health benefit plan features on~~
3402 ~~the exchange and filter the plans based on consumer preferences;]~~

3403 ~~[(ii) the collection of health insurance premium payments made for a single policy by~~
3404 ~~multiple payers, including the policyholder, one or more employers of one or more individuals~~
3405 ~~covered by the policy, government programs, and others; and]~~

3406 ~~[(iii) establishing a call center in accordance with Subsection (4);]~~

3407 ~~[(c) assist employers with a free or low cost method for establishing mechanisms for~~
3408 ~~the purchase of health insurance by employees using pre-tax dollars;]~~

3409 ~~[(d) establish a list on the Health Insurance Exchange of insurance producers who, in~~
3410 ~~accordance with Section 31A-30-209, are appointed producers for the Health Insurance~~
3411 ~~Exchange;]~~

3412 ~~[(e) include in the annual written report described in Section 63N-1-301, a report on~~
3413 ~~the operations of the Health Insurance Exchange required by this chapter; and]~~

3414 ~~[(f) in accordance with Subsection (3), provide a form to a small employer that~~
3415 ~~certifies:]~~

3416 ~~[(i) that the small employer offered a qualified health plan to the small employer's~~
3417 ~~employees; and]~~

3418 ~~[(ii) the period of time within the taxable year in which the small employer maintained~~
3419 ~~the qualified health plan coverage:]~~

3420 ~~[(3) The form required by Subsection (2)(f) shall be provided to a small employer if:]~~

3421 ~~[(a) the small employer selected a qualified health plan on the small employer health~~
3422 ~~exchange created by this section; or]~~

3423 ~~[(b) (i) the small employer selected a health plan in the small employer market that is~~
3424 ~~not offered through the exchange created by this section; and]~~

3425 ~~[(ii) the issuer of the health plan selected by the small employer submits to the office,~~
3426 ~~in a form and manner required by the office:]~~

3427 ~~[(A) an affidavit from a member of the American Academy of Actuaries stating that~~
3428 ~~based on generally accepted actuarial principles and methodologies the issuer's health plan~~
3429 ~~meets the benefit and actuarial requirements for a qualified health plan under PPACA as~~
3430 ~~defined in Section 31A-1-301; and]~~

3431 ~~[(B) an affidavit from the issuer that includes the dates of coverage for the small~~
3432 ~~employer during the taxable year:]~~

3433 ~~[(4) A call center established by the consumer health office:]~~

3434 ~~[(a) shall provide unbiased answers to questions concerning exchange operations, and~~
3435 ~~plan information, to the extent the plan information is posted on the exchange by the insurer;~~
3436 ~~and]~~

3437 ~~[(b) may not:]~~

3438 ~~[(i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;]~~
3439 ~~[(ii) receive producer compensation through the Health Insurance Exchange; and]~~
3440 ~~[(iii) be designated as the default producer for an employer group that enters the Health~~
3441 ~~Insurance Exchange without a producer.]~~
3442 ~~[(5) The consumer health office:]~~
3443 ~~[(a) may not:]~~
3444 ~~[(i) regulate health insurers, health insurance plans, health insurance producers, or~~
3445 ~~health insurance premiums charged in the exchange;]~~
3446 ~~[(ii) adopt administrative rules, except as provided in Section [63N-11-107](#); or]~~
3447 ~~[(iii) act as an appeals entity for resolving disputes between a health insurer and an~~
3448 ~~insured;]~~
3449 ~~[(b) may establish and collect a fee for the cost of the exchange transaction in~~
3450 ~~accordance with Section [63J-1-504](#) for:]~~
3451 ~~[(i) processing an application for a health benefit plan;]~~
3452 ~~[(ii) accepting, processing, and submitting multiple premium payment sources;]~~
3453 ~~[(iii) providing a mechanism for consumers to filter and compare health benefit plans~~
3454 ~~in the exchange based on consumer preferences; and]~~
3455 ~~[(iv) funding the call center; and]~~
3456 ~~[(c) shall separately itemize the fee established under Subsection (5)(b) as part of the~~
3457 ~~cost displayed for the employer selecting coverage on the exchange.]~~
3458 ~~(a) carry out the duties described in Section [63N-11-103](#);~~
3459 ~~(b) maintain the services provided by the office for the Avenue H small employer~~
3460 ~~health insurance exchange until ~~Ĥ~~→ ~~[January 1, 2018; and]~~ operations of Avenue H end under~~
3460a ~~Subsection (2)(d);~~
3460b ~~(c) beginning July 1, 2017, enroll or renew a small employer group with a single insurer~~
3460c ~~selected by the small employer, while allowing for employee choice among health benefit plans~~
3460d ~~offered by the single insurer selected by the small employer; and~~
3461 ~~[(e)] (d) ←Ĥ take steps necessary to wind down the operations of the Avenue H small~~
3461a ~~employer~~
3462 ~~health insurance exchange effective ~~Ĥ~~→ ~~[January]~~ July ←Ĥ 1, 2018.~~
3463 ~~Section 42. **Health Reform Task Force -- Creation -- Membership -- Interim rules**~~
3464 ~~**followed -- Compensation -- Staff.**~~
3465 ~~(1) There is created the Health Reform Task Force consisting of the following 11~~
3466 ~~members:~~
3467 ~~(a) four members of the Senate appointed by the president of the Senate, no more than~~
3468 ~~three of whom may be from the same political party; and~~

3469 (b) seven members of the House of Representatives appointed by the speaker of the
3470 House of Representatives, no more than five of whom may be from the same political party.

3471 (2) (a) The president of the Senate shall designate a member of the Senate appointed
3472 under Subsection (1)(a) as a cochair of the task force.

3473 (b) The speaker of the House of Representatives shall designate a member of the House
3474 of Representatives appointed under Subsection (1)(b) as a cochair of the task force.

3475 (3) In conducting the task force's business, the task force shall comply with the rules of
3476 legislative interim committees.

3477 (4) Salaries and expenses of the members of the task force shall be paid in accordance
3478 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Legislator Compensation.

3479 (5) The Office of Legislative Research and General Counsel shall provide staff support
3480 to the task force.

3481 Section 43. **Duties -- Interim report.**

3482 (1) The task force shall review and make recommendations on the following issues:

3483 (a) the need for state statutory and regulatory changes in response to federal actions
3484 affecting health care;

3485 (b) Medicaid and reforms to the Medicaid program;

3486 (c) options for increasing state flexibility, including the use of federal waivers;

3487 (d) the state's health insurance marketplace;

3488 (e) combining managed care organizations and health insurers into a guaranty

3489 association that includes only health insurers;

3490 (f) health insurance code modifications;

3491 (g) insurance network adequacy standards and balance billing;

3492 (h) access to health care for medically underserved populations in the state; and

3493 (i) the state's strategic plan for health system reform in Section 63N-11-105.

3494 (2) A final report, including any proposed legislation, shall be presented to the
3495 Business and Labor Interim Committee and Health and the Human Services Interim Committee
3496 before November 30, 2017, and November 30, 2018.

3497 Section 44. **Repealer.**

3498 This bill repeals:

3499 Section 31A-22-721, A health benefit plan for a plan sponsor -- Discontinuance

3500 **and nonrenewal.**

3501 Section **31A-30-107, Renewal -- Limitations -- Exclusions -- Discontinuance and**
 3502 **nonrenewal.**

3503 Section **31A-30-107.1, Individual discontinuance and nonrenewal.**

3504 Section **31A-30-107.3, Discontinuance and nonrenewal limitations and conditions.**

3505 Section **31A-30-116, Essential health benefits.**

3506 Section **63N-11-107, Health benefit plan information on Health Insurance**
 3507 **Exchange -- Insurer transparency.**

3508 Section 45. **Appropriation.**

3509 The following sums of money are appropriated for the fiscal year beginning July 1,
 3510 2017, and ending June 30, 2018. These are additions to amounts previously appropriated for
 3511 fiscal year 2018. Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures
 3512 Act, the Legislature appropriates the following sums of money from the funds or accounts
 3513 indicated for the use and support of the government of the state of Utah.

3514 ITEM 1

3515 To Legislature - Senate

3516 From General Fund, One-time \$20,000

3517 Schedule of Programs:

3518 Administration \$20,000

3519 ITEM 2

3520 To Legislature - House of Representatives

3521 From General Fund, One-time \$34,000

3522 Schedule of Programs:

3523 Administration \$34,000

3524 Section 46. **Repeal date.**

3525 The Health Reform Task Force created in Sections 42 and 43 is repealed January 1,
 3526 2019.

3527 Section 47. **Effective date.**

3528 (1) Except as provided in Subsections (2) and (3), this bill takes effect on May 9, 2017.

3529 (2) The actions affecting the following sections take effect on January 1, 2018:

3530 (a) Section **31A-22-610.1;**

- 3531 (b) Section 31A-22-618;
3532 (c) Section 31A-22-618.5;
3533 (d) Section 31A-22-627;
3534 (e) Section 31A-22-635;
3535 (f) Section 31A-22-642;
3536 (g) Section 31A-45-101;
3537 (h) Section 31A-45-102;
3538 (i) Section 31A-45-103;
3539 (j) Section 31A-45-201;
3540 (k) Section 31A-45-301;
3541 (l) Section 31A-45-302;
3542 (m) Section 31A-45-303;
3543 (n) Section 31A-45-304;
3544 (o) Section 31A-45-401;
3545 (p) Section 31A-45-402;
3546 (q) Section 31A-45-501;
3547 (r) Section 49-20-407; and
3548 (s) Section 58-16a-601.
3549 (3) The repeal of Section 63N-11-107 takes effect on $\hat{H} \rightarrow$ [January] July $\leftarrow \hat{H}$ 1, 2018.

Legislative Review Note
Office of Legislative Research and General Counsel