

1 **INSURANCE RELATED MODIFICATIONS**

2 2017 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: James A. Dunnigan**

5 Senate Sponsor: Curtis S. Bramble

7 **LONG TITLE**

8 **General Description:**

9 This bill modifies provisions related to insurance.

10 **Highlighted Provisions:**

11 This bill:

- 12 ▶ modifies enforcement penalties and procedures;
- 13 ▶ replaces the term "health benefit product" with "health benefit plan";
- 14 ▶ clarifies that rules are made under Title 63G, Chapter 3, Utah Administrative

15 Rulemaking Act;

- 16 ▶ addresses taxation;
- 17 ▶ requires licensees who are foreign insurers to provide contact information and
- 18 maintain certain records;

- 19 ▶ modifies due date of insurer holding company filing;
- 20 ▶ enacts the Risk Management and Own Risk and Solvency Assessment Act,

21 including:

- 22 • providing the scope of the chapter;
- 23 • defining terms;
- 24 • requiring a risk management framework;
- 25 • requiring an own risk and solvency assessment;
- 26 • providing for a summary report and its contents;
- 27 • providing for exemptions;
- 28 • addressing confidentiality;

- 29 • establishing sanctions; and
- 30 • providing a severability clause;
- 31 ▶ addresses risk based capital provisions;
- 32 ▶ addresses association groups;
- 33 ▶ modifies accident and health insurance standards provisions;
- 34 ▶ moves provision for when a child of a group member may be denied eligibility;
- 35 ▶ clarifies preferred provider contract provisions;
- 36 ▶ addresses when a person is required to provide information concerning an employer
- 37 self-insured employee welfare benefit plan;
- 38 ▶ moves provisions related to alcohol and drug dependency treatment;
- 39 ▶ addresses groups eligible for group or blanket insurance;
- 40 ▶ modifies provisions related to requirements for notice of termination;
- 41 ▶ addresses scope of part of credit life and accident and health insurance;
- 42 ▶ amends definitions under the Unclaimed Life Insurance and Annuity Benefits Act;
- 43 ▶ provides for the assessment of forfeitures;
- 44 ▶ provides for notice to a producer of the termination of appointment;
- 45 ▶ addresses when an insurer has a contract with a licensee;
- 46 ▶ imposes requirements related to flood insurance;
- 47 ▶ addresses licensed compensation;
- 48 ▶ provides for notice to a designee when an agency terminates the designation,
- 49 including navigator agencies;
- 50 ▶ addresses contracts with agencies;
- 51 ▶ addresses contracts with individual title insurance producer or an agency title
- 52 insurance producer;
- 53 ▶ requires certain record keeping requirements;
- 54 ▶ addresses reports from organizations licensed as adjusters;
- 55 ▶ enacts provisions related to adjusters;

- 56 ▶ modifies provisions related to captive insurers, including:
 - 57 • amending definitions;
 - 58 • addressing permissive areas of insurance;
 - 59 • addressing capital issues;
 - 60 • modifying provisions required for formation;
 - 61 • providing that captive insurance companies may cede risks to certain insurers;
 - 62 • addressing contributions to guaranty of insolvency funds; and
 - 63 • repealing provisions related to an association captive or industrial insured
 - 64 group;
- 65 ▶ amends board of directors provisions under the Defined Contribution Risk Adjuster
- 66 Act;
- 67 ▶ imposes record retention requirements under the Continuing Care Provider Act;
- 68 ▶ repeals the Voluntary Health Insurance Purchasing Alliance Act; and
- 69 ▶ makes technical and conforming amendments.

70 **Money Appropriated in this Bill:**

71 None

72 **Other Special Clauses:**

73 This bill provides retrospective operation.

74 **Utah Code Sections Affected:**

75 AMENDS:

76 16-6a-207, as last amended by Laws of Utah 2008, Chapter 363

77 16-6a-301, as enacted by Laws of Utah 2000, Chapter 300

78 31A-2-308, as last amended by Laws of Utah 2012, Chapter 253

79 31A-3-102, as last amended by Laws of Utah 2014, Chapter 435

80 31A-3-205, as enacted by Laws of Utah 2005, Chapter 123

81 31A-3-304, as last amended by Laws of Utah 2015, Chapter 244

82 31A-8-402.3, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425

- 83 **31A-8-402.5**, as last amended by Laws of Utah 2003, Chapter 252
- 84 **31A-16-105**, as last amended by Laws of Utah 2015, Chapter 244
- 85 **31A-17-404**, as last amended by Laws of Utah 2016, Chapter 138
- 86 **31A-17-603**, as last amended by Laws of Utah 2013, Chapter 319
- 87 **31A-22-505**, as enacted by Laws of Utah 1985, Chapter 242
- 88 **31A-22-605**, as last amended by Laws of Utah 2005, Chapter 78
- 89 **31A-22-610.5**, as last amended by Laws of Utah 2011, Chapter 297
- 90 **31A-22-614.5**, as last amended by Laws of Utah 2011, Chapter 284
- 91 **31A-22-617**, as last amended by Laws of Utah 2014, Chapters 290 and 300
- 92 **31A-22-701**, as last amended by Laws of Utah 2011, Chapter 284
- 93 **31A-22-716**, as last amended by Laws of Utah 2011, Chapters 284 and 297
- 94 **31A-22-721**, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
- 95 **31A-22-801**, as last amended by Laws of Utah 2001, Chapter 116
- 96 **31A-22-1902**, as enacted by Laws of Utah 2015, Chapter 259
- 97 **31A-23a-111**, as last amended by Laws of Utah 2016, Chapter 138
- 98 **31A-23a-115**, as last amended by Laws of Utah 2009, Chapter 349
- 99 **31A-23a-203**, as last amended by Laws of Utah 2014, Chapters 290 and 300
- 100 **31A-23a-302**, as last amended by Laws of Utah 2012, Chapter 253
- 101 **31A-23a-407**, as last amended by Laws of Utah 2016, Chapter 314
- 102 **31A-23a-412**, as last amended by Laws of Utah 2012, Chapter 253
- 103 **31A-23a-501**, as last amended by Laws of Utah 2016, Chapter 138
- 104 **31A-23b-102**, as last amended by Laws of Utah 2014, Chapters 290 and 300
- 105 **31A-23b-202.5**, as enacted by Laws of Utah 2014, Chapter 425
- 106 **31A-23b-209**, as enacted by Laws of Utah 2013, Chapter 341
- 107 **31A-23b-210**, as enacted by Laws of Utah 2013, Chapter 341
- 108 **31A-23b-401**, as last amended by Laws of Utah 2016, Chapter 138
- 109 **31A-26-209**, as last amended by Laws of Utah 2004, Chapter 173

- 110 [31A-26-210](#), as last amended by Laws of Utah 2009, Chapter 349
- 111 [31A-26-213](#), as last amended by Laws of Utah 2016, Chapter 138
- 112 [31A-30-106](#), as last amended by Laws of Utah 2014, Chapters 290 and 300
- 113 [31A-30-106.1](#), as last amended by Laws of Utah 2012, Chapter 279
- 114 [31A-30-107](#), as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
- 115 [31A-30-107.1](#), as last amended by Laws of Utah 2003, Chapter 252
- 116 [31A-35-103](#), as last amended by Laws of Utah 2016, Chapter 234
- 117 [31A-37-102](#), as last amended by Laws of Utah 2016, Chapter 138
- 118 [31A-37-106](#), as last amended by Laws of Utah 2015, Chapter 244
- 119 [31A-37-202](#), as last amended by Laws of Utah 2015, Chapter 244
- 120 [31A-37-204](#), as last amended by Laws of Utah 2016, Chapter 138
- 121 [31A-37-301](#), as last amended by Laws of Utah 2016, Chapter 348
- 122 [31A-37-303](#), as last amended by Laws of Utah 2016, Chapter 138
- 123 [31A-37-305](#), as enacted by Laws of Utah 2003, Chapter 251
- 124 [31A-42-201](#), as last amended by Laws of Utah 2010, Chapters 10 and 68
- 125 [31A-44-603](#), as enacted by Laws of Utah 2016, Chapter 270
- 126 [53-2a-1102](#), as last amended by Laws of Utah 2015, Chapter 408
- 127 [59-7-102](#), as last amended by Laws of Utah 2014, Chapters 376 and 435
- 128 [59-9-101](#), as last amended by Laws of Utah 2016, Chapter 135
- 129 [63G-2-302](#), as last amended by Laws of Utah 2016, Chapter 410

130 ENACTS:

- 131 [31A-14-205.5](#), Utah Code Annotated 1953
- 132 [31A-16a-101](#), Utah Code Annotated 1953
- 133 [31A-16a-102](#), Utah Code Annotated 1953
- 134 [31A-16a-103](#), Utah Code Annotated 1953
- 135 [31A-16a-104](#), Utah Code Annotated 1953
- 136 [31A-16a-105](#), Utah Code Annotated 1953

- 137 **31A-16a-106**, Utah Code Annotated 1953
- 138 **31A-16a-107**, Utah Code Annotated 1953
- 139 **31A-16a-108**, Utah Code Annotated 1953
- 140 **31A-16a-109**, Utah Code Annotated 1953
- 141 **31A-16a-110**, Utah Code Annotated 1953
- 142 **31A-22-645**, Utah Code Annotated 1953
- 143 **31A-26-312**, Utah Code Annotated 1953
- 144 **31A-26-401**, Utah Code Annotated 1953
- 145 **31A-26-402**, Utah Code Annotated 1953
- 146 **31A-26-403**, Utah Code Annotated 1953

147 REPEALS:

- 148 **31A-22-715**, as last amended by Laws of Utah 2016, Chapter 138
- 149 **31A-22-718**, as enacted by Laws of Utah 1995, Chapter 344
- 150 **31A-34-101**, as enacted by Laws of Utah 1996, Chapter 143
- 151 **31A-34-102**, as enacted by Laws of Utah 1996, Chapter 143
- 152 **31A-34-103**, as enacted by Laws of Utah 1996, Chapter 143
- 153 **31A-34-104**, as last amended by Laws of Utah 2011, Chapter 297
- 154 **31A-34-105**, as last amended by Laws of Utah 2000, Chapter 300
- 155 **31A-34-106**, as enacted by Laws of Utah 1996, Chapter 143
- 156 **31A-34-107**, as last amended by Laws of Utah 2011, Chapter 297
- 157 **31A-34-108**, as last amended by Laws of Utah 2000, Chapter 300
- 158 **31A-34-109**, as enacted by Laws of Utah 1996, Chapter 143
- 159 **31A-34-110**, as last amended by Laws of Utah 2001, Chapter 108
- 160 **31A-34-111**, as enacted by Laws of Utah 1996, Chapter 143
- 161 **31A-37-306**, as last amended by Laws of Utah 2015, Chapter 244



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

164 Section 1. Section **16-6a-207** is amended to read:

165 **16-6a-207. Incorporation of cooperative association.**

166 (1) (a) If a cooperative association meets the requirements of Subsection (1)(b), it may:

167 (i) be incorporated under this chapter; and

168 (ii) use the word "cooperative" as part of its corporate or business name.

169 (b) A cooperative association described in Subsection (1)(a):

170 (i) may not be~~[-(A)]~~ an association subject to the insurance or credit union laws of this
171 state; and

172 [~~(B) a health insurance purchasing association as defined in Section 31A-34-103; or]~~

173 [~~(C) a health insurance purchasing alliance licensed under Title 31A, Chapter 34,~~

174 ~~Voluntary Health Insurance Purchasing Alliance Act; and]~~

175 (ii) shall state in its articles of incorporation that:

176 (A) a member may not have more than one vote regardless of the number or amount of
177 stock or membership capital owned by the member unless voting is based in whole or in part
178 on the volume of patronage of the member with the cooperative association; and

179 (B) savings in excess of dividends and additions to reserves and surplus shall be
180 distributed or allocated to members or patrons on the basis of patronage.

181 (2) (a) Any cooperative association incorporated in accordance with Subsection (1):

182 (i) has all the rights and is subject to the limitations provided in Section 3-1-11; and

183 (ii) may pay dividends on its stock, if it has stock, subject to the limitations of Section
184 3-1-11.

185 (b) The articles of incorporation or the bylaws of a cooperative association
186 incorporated in accordance with Subsection (1) may provide for:

187 (i) the establishment and alteration of voting districts;

188 (ii) the election of delegates to represent:

189 (A) the districts described in Subsection (2)(b)(i); and

190 (B) the members of the districts described in Subsection (2)(b)(i);

191 (iii) the establishment and alteration of director districts; and
192 (iv) the election of directors to represent the districts described in Subsection (2)(b)(ii)
193 by:

- 194 (A) the members of the districts; or
- 195 (B) delegates elected by the members.

196 (3) (a) A corporation organized under Title 3, Uniform Agricultural Cooperative
197 Association Act, or Title 16, Chapter 16, Uniform Limited Cooperative Association Act, may
198 convert itself into a cooperative association subject to this chapter by adopting appropriate
199 amendments to its articles of incorporation by which:

- 200 (i) it elects to become subject to this chapter; and
- 201 (ii) makes changes in its articles of incorporation that are:
 - 202 (A) required by this chapter; and
 - 203 (B) any other changes permitted by this chapter.

204 (b) The amendments described in Subsection (3)(a) shall be adopted and filed in the
205 manner provided by the law then applicable to the cooperative nonprofit corporation.

206 ~~[(4) Notwithstanding Subsection (1), a health insurance purchasing association may not~~
207 ~~use the word "cooperative" or "alliance" but may use the word "association."]~~

208 ~~[(5)]~~ (4) Except as otherwise provided in this section, a cooperative nonprofit
209 corporation is subject to this chapter.

210 ~~[(6)]~~ (5) A corporation that is a cooperative under this chapter may convert to a limited
211 cooperative association under Title 16, Chapter 16, Uniform Limited Cooperative Association
212 Act, by complying with that chapter.

213 Section 2. Section **16-6a-301** is amended to read:

214 **16-6a-301. Purposes.**

215 (1) Every nonprofit corporation incorporated under this chapter that in its articles of
216 incorporation has a statement meeting the requirements of Subsection **16-6a-202(3)(a)** may
217 engage in any lawful activity except for express limitations set forth in the articles of

218 incorporation.

219 (2) (a) A nonprofit corporation engaging in an activity that is subject to regulation
220 under another statute of this state may incorporate under this chapter only if permitted by, and
221 subject to all limitations of, the other statute.

222 (b) Without limiting Subsection (2)(a) and subject to Subsection (2)(c), an organization
223 may not be organized under this chapter if the organization is subject to the:

224 (i) insurance laws of this state; or

225 (ii) laws governing depository institutions as defined in Section 7-1-103.

226 ~~[(c) Notwithstanding Subsection (2)(b), the following may be organized under this~~
227 ~~chapter:]~~

228 ~~[(i) a health insurance purchasing association as defined in Section 31A-34-103; and]~~

229 ~~[(ii) a health insurance purchasing alliance licensed under Title 31A, Chapter 34,~~
230 ~~Voluntary Health Insurance Purchasing Alliance Act.]~~

231 Section 3. Section 31A-2-308 is amended to read:

232 **31A-2-308. Enforcement penalties and procedures.**

233 (1) (a) A person who violates any insurance statute or rule or any order issued under
234 Subsection 31A-2-201(4) shall forfeit to the state twice the amount of any profit gained from
235 the violation, in addition to any other forfeiture or penalty imposed.

236 (b) (i) The commissioner may order an individual producer, surplus line producer,
237 limited line producer, managing general agent, reinsurance intermediary, adjuster, third party
238 administrator, navigator, or insurance consultant who violates an insurance statute or rule to
239 forfeit to the state not more than \$2,500 for each violation.

240 (ii) The commissioner may order any other person who violates an insurance statute or
241 rule to forfeit to the state not more than \$5,000 for each violation.

242 (c) (i) The commissioner may order an individual producer, surplus line producer,
243 limited line producer, managing general agent, reinsurance intermediary, adjuster, third party
244 administrator, navigator, or insurance consultant who violates an order issued under Subsection

245 31A-2-201(4) to forfeit to the state not more than \$2,500 for each violation. Each day the
246 violation continues is a separate violation.

247 (ii) The commissioner may order any other person who violates an order issued under
248 Subsection 31A-2-201(4) to forfeit to the state not more than \$5,000 for each violation. Each
249 day the violation continues is a separate violation.

250 (d) The commissioner may accept or compromise any forfeiture under this Subsection
251 (1) until after a complaint is filed under Subsection (2). After the filing of the complaint, only
252 the attorney general may compromise the forfeiture.

253 (2) When a person fails to comply with an order issued under Subsection
254 31A-2-201(4), including a forfeiture order, the commissioner may file an action in any court of
255 competent jurisdiction or obtain a court order or judgment:

256 (a) enforcing the commissioner's order;

257 (b) (i) directing compliance with the commissioner's order and restraining further
258 violation of the order; and

259 (ii) subjecting the person ordered to the procedures and sanctions available to the court
260 for punishing contempt if the failure to comply continues; or

261 (c) imposing a forfeiture in an amount the court considers just, up to \$10,000 for each
262 day the failure to comply continues after the filing of the complaint until judgment is rendered.

263 (3) (a) The Utah Rules of Civil Procedure govern actions brought under Subsection (2),
264 except that the commissioner may file a complaint seeking a court-ordered forfeiture under
265 Subsection (2)(c) no sooner than two weeks after giving written notice of the commissioner's
266 intention to proceed under Subsection (2)(c).

267 (b) The commissioner's order issued under Subsection 31A-2-201(4) may contain a
268 notice of intention to seek a court-ordered forfeiture if the commissioner's order is disobeyed.

269 (4) If, after a court order is issued under Subsection (2), the person fails to comply with
270 the commissioner's order or judgment:

271 (a) the commissioner may certify the fact of the failure to the court by affidavit; and

272 (b) the court may, after a hearing following at least five days written notice to the
273 parties subject to the order or judgment, amend the order or judgment to add the forfeiture or
274 forfeitures, as prescribed in Subsection (2)(c), until the person complies.

275 (5) (a) The proceeds of the forfeitures under this section, including collection expenses,
276 shall be paid into the General Fund.

277 (b) The expenses of collection shall be credited to the department's budget.

278 (c) The attorney general's budget shall be credited to the extent the department
279 reimburses the attorney general's office for its collection expenses under this section.

280 (6) (a) Forfeitures and judgments under this section bear interest at the rate charged by
281 the United States Internal Revenue Service for past due taxes on the:

282 (i) date of entry of the commissioner's order under Subsection (1); or

283 (ii) date of judgment under Subsection (2).

284 (b) Interest accrues from the later of the dates described in Subsection (6)(a) until the
285 forfeiture and accrued interest are fully paid.

286 (7) A forfeiture may not be imposed under Subsection (2)(c) if:

287 (a) at the time the forfeiture action is commenced, the person was in compliance with
288 the commissioner's order; or

289 (b) the violation of the order occurred during the order's suspension.

290 (8) The commissioner may seek an injunction as an alternative to issuing an order
291 under Subsection 31A-2-201(4).

292 (9) (a) A person is guilty of a class B misdemeanor if that person:

293 (i) intentionally violates:

294 (A) an insurance statute of this state; or

295 (B) an order issued under Subsection 31A-2-201(4);

296 (ii) intentionally permits a person over whom that person has authority to violate:

297 (A) an insurance statute of this state; or

298 (B) an order issued under Subsection 31A-2-201(4); or

299 (iii) intentionally aids any person in violating:
300 (A) an insurance statute of this state; or
301 (B) an order issued under Subsection 31A-2-201(4).
302 (b) Unless a specific criminal penalty is provided elsewhere in this title, the person may
303 be fined not more than:
304 (i) \$10,000 if a corporation; or
305 (ii) \$5,000 if a person other than a corporation.
306 (c) If the person is an individual, the person may, in addition, be imprisoned for up to
307 one year.
308 (d) As used in this Subsection (9), "intentionally" has the same meaning as under
309 Subsection 76-2-103(1).
310 (10) (a) A person who knowingly and intentionally violates Section 31A-4-102,
311 31A-8a-208, 31A-15-105, 31A-23a-116, or 31A-31-111 is guilty of a felony as provided in this
312 Subsection (10).
313 (b) When the value of the property, money, or other things obtained or sought to be
314 obtained in violation of Subsection (10)(a):
315 (i) is less than \$5,000, a person is guilty of a third degree felony; or
316 (ii) is or exceeds \$5,000, a person is guilty of a second degree felony.
317 (11) (a) After a hearing, the commissioner may, in whole or in part, revoke, suspend,
318 place on probation, limit, or refuse to renew the licensee's license or certificate of authority:
319 (i) when a licensee of the department, other than a domestic insurer:
320 (A) persistently or substantially violates the insurance law; or
321 (B) violates an order of the commissioner under Subsection 31A-2-201(4);
322 (ii) if there are grounds for delinquency proceedings against the licensee under Section
323 31A-27a-207; or
324 (iii) if the licensee's methods and practices in the conduct of the licensee's business
325 endanger, or the licensee's financial resources are inadequate to safeguard, the legitimate

326 interests of the licensee's customers and the public.

327 (b) Additional license termination or probation provisions for licensees other than
328 insurers are set forth in Sections [31A-19a-303](#), [31A-19a-304](#), [31A-23a-111](#), [31A-23a-112](#),
329 [31A-25-208](#), [31A-25-209](#), [31A-26-213](#), [31A-26-214](#), [31A-35-501](#), and [31A-35-503](#).

330 (12) The enforcement penalties and procedures set forth in this section are not
331 exclusive, but are cumulative of other rights and remedies the commissioner has pursuant to
332 applicable law.

333 Section 4. Section **31A-3-102** is amended to read:

334 **31A-3-102. Exclusive fees and taxes.**

335 (1) The following are in place of any other license fee or license assessment that might
336 otherwise be levied against a licensee by the state or a political subdivision of the state:

337 (a) taxes and fees under this chapter[;];

338 (b) the premium taxes under [Sections ~~59-9-101~~ through ~~59-9-104~~], Title 59, Chapter
339 9, Taxation of Admitted Insurers;

340 (c) the fees under Section [31A-31-108](#)[;]; and

341 (d) the examination costs under Section [31A-2-205](#) [are in place of all other license
342 fees or assessments that might otherwise be levied by the state or any other taxing body within
343 the state].

344 [~~2~~] An]

345 (2) The following are not subject to Title 59, Chapter 7, Corporate Franchise and
346 Income Taxes:

347 (a) an insurer that is subject to premium taxes under [Sections ~~59-9-101~~ through
348 ~~59-9-104~~ is not subject to corporate franchise taxes.] Title 59, Chapter 9, Taxation of Admitted
349 Insurers, regardless of whether the insurance company has a tax liability under that chapter;

350 (b) an insurance company that engages in a transaction that is subject to taxes under
351 Section [31A-3-301](#) or [31A-3-302](#), regardless of whether the insurance company has a tax
352 liability under that section; and

353 (c) a captive insurance company as provided in Section 31A-3-304 that pays a fee
354 imposed under Section 31A-3-304.

355 (3) Unless otherwise exempt, a licensee under this title is subject to real and personal
356 property taxes.

357 Section 5. Section 31A-3-205 is amended to read:

358 **31A-3-205. Taxation of insurance companies.**

359 (1) An admitted insurer shall pay to the State Tax Commission taxes imposed on the
360 admitted insurer by Title 59, Revenue and Taxation.

361 (2) A surplus lines insurer shall pay the taxes due under Section 31A-3-301 or
362 31A-3-302 in accordance with Section 31A-3-303.

363 Section 6. Section 31A-3-304 is amended to read:

364 **31A-3-304. Annual fees -- Other taxes or fees prohibited -- Captive Insurance**
365 **Restricted Account.**

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

368 (b) The commissioner shall:

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

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

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

374 ~~[(3)(a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter~~
375 ~~9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under~~
376 ~~the laws of this state that may be levied or assessed on a captive insurance company:]~~

377 (3) (a) A captive insurance company that pays one of the following fees is exempt from
378 Title 59, Chapter 7, Corporate Franchise and Income Taxes, and Title 59, Chapter 9, Taxation
379 of Admitted Insurers:

- 380 (i) a fee under this section;
- 381 (ii) a fee under Chapter 37, Captive Insurance Companies Act; ~~[and]~~ or
- 382 (iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company

383 Act.

384 (b) The state or a county, city, or town within the state may not levy or collect an
385 occupation tax or other ~~[tax,]~~ fee~~;~~ or charge not described in Subsections (3)(a)(i) through (iii)
386 against a captive insurance company.

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

389 ~~[(d) A captive insurance company is subject to real and personal property taxes.]~~

390 (4) A captive insurance company shall pay the fee imposed by this section to the
391 commissioner by June 1 of each year.

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

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

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

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

- 401 (i) administer and enforce:
 - 402 (A) Chapter 37, Captive Insurance Companies Act; and
 - 403 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and
- 404 (ii) promote the captive insurance industry in Utah.

405 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,
406 except that at the end of each fiscal year, money received by the commissioner in excess of the

407 following shall be treated as free revenue in the General Fund:

- 408 (i) for fiscal year 2015-2016, in excess of \$1,250,000;
- 409 (ii) for fiscal year 2016-2017, in excess of \$1,250,000; and
- 410 (iii) for fiscal year 2017-2018 and subsequent fiscal years, in excess of \$1,850,000.

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

412 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**
413 **plans.**

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

- 416 (a) with respect to all eligible employees and dependents; and
- 417 (b) at the option of the plan sponsor.

418 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed for a
419 network plan, if:

420 (a) there is no longer any enrollee under the group health plan who lives, resides, or
421 works in:

- 422 (i) the service area of the insurer; or
- 423 (ii) the area for which the insurer is authorized to do business; or

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

- 426 (i) the employer's membership in the association ceases; and
- 427 (ii) the coverage is terminated uniformly without regard to any health status-related
428 factor relating to any covered individual.

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

- 430 (a) a condition described in Subsection (2) exists;
- 431 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
432 terms of the contract;
- 433 (c) the plan sponsor:

- 434 (i) performs an act or practice that constitutes fraud; or
- 435 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 436 coverage;
- 437 (d) the insurer:
- 438 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or
- 439 issued for delivery in this state; and
- 440 (ii) (A) provides notice of the discontinuation in writing:
 - 441 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
 - 442 (II) at least 90 days before the date the coverage will be discontinued;
- 443 (B) provides notice of the discontinuation in writing:
 - 444 (I) to the commissioner; and
 - 445 (II) at least three working days prior to the date the notice is sent to the affected plan
 - 446 sponsors, employees, and dependents of the plan sponsors or employees;
- 447 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
 - 448 (I) all other health benefit [~~products~~] plans currently being offered by the insurer in the
 - 449 market; or
 - 450 (II) in the case of a large employer, any other health benefit [~~product~~] plan currently
 - 451 being offered in that market; and
- 452 (D) in exercising the option to discontinue that [~~product~~] health benefit plan and in
- 453 offering the option of coverage in this section, acts uniformly without regard to:
 - 454 (I) the claims experience of a plan sponsor;
 - 455 (II) any health status-related factor relating to any covered participant or beneficiary; or
 - 456 (III) any health status-related factor relating to any new participant or beneficiary who
 - 457 may become eligible for the coverage; or
- 458 (e) the insurer:
 - 459 (i) elects to discontinue all of the insurer's health benefit plans in:
 - 460 (A) the small employer market;

- 461 (B) the large employer market; or
- 462 (C) both the small employer and large employer markets; and
- 463 (ii) (A) provides notice of the discontinuation in writing:
 - 464 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
 - 465 (II) at least 180 days before the date the coverage will be discontinued;
- 466 (B) provides notice of the discontinuation in writing:
 - 467 (I) to the commissioner in each state in which an affected insured individual is known
 - 468 to reside; and
 - 469 (II) at least 30 working days prior to the date the notice is sent to the affected plan
 - 470 sponsors, employees, and the dependents of the plan sponsors or employees;
- 471 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
- 472 market; and
- 473 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
- 474 (4) A large employer health benefit plan may be discontinued or nonrenewed:
 - 475 (a) if a condition described in Subsection (2) exists; or
 - 476 (b) for noncompliance with the insurer's:
 - 477 (i) minimum participation requirements; or
 - 478 (ii) employer contribution requirements.
- 479 (5) A small employer health benefit plan may be discontinued or nonrenewed:
 - 480 (a) if a condition described in Subsection (2) exists; or
 - 481 (b) for noncompliance with the insurer's employer contribution requirements.
- 482 (6) A small employer health benefit plan may be nonrenewed:
 - 483 (a) if a condition described in Subsection (2) exists; or
 - 484 (b) for noncompliance with the insurer's minimum participation requirements.
- 485 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
- 486 discontinued if after issuance of coverage the eligible employee:
 - 487 (i) engages in an act or practice in connection with the coverage that constitutes fraud;

488 or

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

491 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:

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

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

495 (c) At the time the eligible employee's coverage is discontinued under Subsection
496 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
497 discontinued.

498 (d) An eligible employee may not be discontinued under this Subsection (7) because of
499 a fraud or misrepresentation that relates to health status.

500 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to
501 the employer:

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

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

505 (i) an association;

506 (ii) a trust; or

507 (iii) a discretionary group.

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

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

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

511 Section 8. Section **31A-8-402.5** is amended to read:

512 **31A-8-402.5. Individual discontinuance and nonrenewal.**

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

- 515 (i) with respect to all individuals or dependents; and
- 516 (ii) at the option of the individual.
- 517 (b) Subsection (1)(a) applies regardless of:
- 518 (i) whether the contract is issued through:
- 519 (A) a trust;
- 520 (B) an association;
- 521 (C) a discretionary group; or
- 522 (D) other similar grouping; or
- 523 (ii) the situs of delivery of the policy or contract.
- 524 (2) A health benefit plan may be discontinued or nonrenewed:
- 525 (a) for a network plan, if:
- 526 (i) the individual no longer lives, resides, or works in:
- 527 (A) the service area of the insurer; or
- 528 (B) the area for which the insurer is authorized to do business; and
- 529 (ii) coverage is terminated uniformly without regard to any health status-related factor
- 530 relating to any covered individual; or
- 531 (b) for coverage made available through an association, if:
- 532 (i) the individual's membership in the association ceases; and
- 533 (ii) the coverage is terminated uniformly without regard to any health status-related
- 534 factor relating to any covered individual.
- 535 (3) A health benefit plan may be discontinued if:
- 536 (a) a condition described in Subsection (2) exists;
- 537 (b) the individual fails to pay premiums or contributions in accordance with the terms
- 538 of the health benefit plan, including any timeliness requirements;
- 539 (c) the individual:
- 540 (i) performs an act or practice in connection with the coverage that constitutes fraud; or
- 541 (ii) makes an intentional misrepresentation of material fact under the terms of the

542 coverage;

543 (d) the insurer:

544 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or

545 issued for delivery in this state; and

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

547 (I) to each individual provided coverage; and

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

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

550 (I) to the commissioner; and

551 (II) at least three working days prior to the date the notice is sent to the affected

552 individuals;

553 (C) offers to each covered individual on a guaranteed issue basis, the option to

554 purchase all other individual health benefit [~~products~~] plans currently being offered by the

555 insurer for individuals in that market; and

556 (D) acts uniformly without regard to any health status-related factor of covered

557 individuals or dependents of covered individuals who may become eligible for coverage; or

558 (e) the insurer:

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

560 and

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

562 (I) to each individual provided coverage; and

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

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

565 (I) to the commissioner in each state in which an affected insured individual is known

566 to reside; and

567 (II) at least 30 working days prior to the date the notice is sent to the affected

568 individuals;

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

571 (D) acts uniformly without regard to any health status-related factor of covered
572 individuals or dependents of covered individuals who may become eligible for coverage.

573 Section 9. Section 31A-14-205.5 is enacted to read:

574 **31A-14-205.5. Place of business address information -- Record retention.**

575 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:

576 (i) the address and the one or more telephone numbers of the licensee's principal place
577 of business; and

578 (ii) a valid business email address at which the commissioner may contact the licensee.

579 (b) A licensee shall notify the commissioner within 30 days of a change of any of the
580 following required to be registered with the commissioner under this section:

581 (i) an address;

582 (ii) a telephone number; or

583 (iii) a business email address.

584 (2) (a) Except as provided under Subsection (3), a licensee under this chapter shall
585 keep at the address of the principal place of business registered under Subsection (1), separate
586 and distinct books and records of the transactions consummated under the Utah license.

587 (b) The books and records described in Subsection (2)(a) shall:

588 (i) be in an organized form; and

589 (ii) be available to the commissioner for inspection upon reasonable notice.

590 (c) The books and records described in Subsection (2)(a) shall include the following:

591 (i) if the licensee is a foreign insurer, alien insurer, commercially domiciled insurer,
592 foreign title insurer, or foreign fraternal:

593 (A) a record of each insurance contract procured by or issued through the licensee, with
594 the names of the one or more insureds, the amount of premium and commissions or other
595 compensation, and the subject of the insurance;

596 (B) the name of any other producer, surplus lines producer, limited line producer,
597 consultant, managing general agent, or reinsurance intermediary from whom business is
598 accepted, and of a person to whom commissions or allowances of any kind are promised or
599 paid; and

600 (C) a record of the consumer complaints forwarded to the licensee by an insurance
601 regulator; and

602 (ii) any additional information that:

603 (A) is customary for a similar business; or

604 (B) may reasonably be required by the commissioner by rule made in accordance with
605 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

606 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can
607 be obtained immediately from a central storage place or elsewhere by online computer
608 terminals located at the registered address.

609 (4) A licensee who represents only a single insurer satisfies Subsection (2) if the
610 insurer maintains the books and records pursuant to Subsection (2) at a place satisfying
611 Subsections (1) and (5).

612 (5) (a) The books and records maintained under Subsection (2) shall be available for
613 the inspection of the commissioner during the business hours for a period of time after the date
614 of the transaction as specified by the commissioner by rule, made in accordance with Title
615 63G, Chapter 3, Utah Administrative Rulemaking Act, but in no case for less than three
616 calendar years in addition to the current calendar year.

617 (b) Discarding a book or record after the applicable record retention period has expired
618 does not place the licensee in violation of a later-adopted longer record retention period.

619 Section 10. Section **31A-16-105** is amended to read:

620 **31A-16-105. Registration of insurers.**

621 (1) (a) An insurer that is authorized to do business in this state and that is a member of
622 an insurance holding company system shall register with the commissioner, except a foreign

623 insurer subject to registration requirements and standards adopted by statute or regulation in the
624 jurisdiction of its domicile, if the requirements and standards are substantially similar to those
625 contained in this section, Subsections 31A-16-106(1)(a) and (2) and either Subsection
626 31A-16-106(1)(b) or a statutory provision similar to the following: "Each registered insurer
627 shall keep current the information required to be disclosed in its registration statement by
628 reporting all material changes or additions within 15 days after the end of the month in which it
629 learns of each change or addition."

630 (b) An insurer that is subject to registration under this section shall register within 15
631 days after it becomes subject to registration, and annually thereafter by ~~May 1~~ June 30 of each
632 year for the previous calendar year, unless the commissioner for good cause extends the time
633 for registration and then at the end of the extended time period. The commissioner may require
634 any insurer authorized to do business in the state, which is a member of a holding company
635 system, and which is not subject to registration under this section, to furnish a copy of the
636 registration statement, the summary specified in Subsection (3), or any other information filed
637 by the insurer with the insurance regulatory authority of domiciliary jurisdiction.

638 (2) An insurer subject to registration shall file the registration statement with the
639 commissioner on a form and in a format prescribed by the National Association of Insurance
640 Commissioners, which shall contain the following current information:

641 (a) the capital structure, general financial condition, and ownership and management of
642 the insurer and any person controlling the insurer;

643 (b) the identity and relationship of every member of the insurance holding company
644 system;

645 (c) any of the following agreements in force, and transactions currently outstanding or
646 which have occurred during the last calendar year between the insurer and its affiliates:

647 (i) loans, other investments, or purchases, sales or exchanges of securities of the
648 affiliates by the insurer or of securities of the insurer by its affiliates;

649 (ii) purchases, sales, or exchanges of assets;

- 650 (iii) transactions not in the ordinary course of business;
- 651 (iv) guarantees or undertakings for the benefit of an affiliate which result in an actual
652 contingent exposure of the insurer's assets to liability, other than insurance contracts entered
653 into in the ordinary course of the insurer's business;
- 654 (v) all management agreements, service contracts, and all cost-sharing arrangements;
- 655 (vi) reinsurance agreements;
- 656 (vii) dividends and other distributions to shareholders; and
- 657 (viii) consolidated tax allocation agreements;
- 658 (d) any pledge of the insurer's stock, including stock of any subsidiary or controlling
659 affiliate, for a loan made to any member of the insurance holding company system;
- 660 (e) if requested by the commissioner, financial statements of or within an insurance
661 holding company system, including all affiliates:
 - 662 (i) which may include annual audited financial statements filed with the United States
663 Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended, or
664 the Securities Exchange Act of 1934, as amended; and
 - 665 (ii) which request is satisfied by providing the commissioner with the most recently
666 filed parent corporation financial statements that have been filed with the United States
667 Securities and Exchange Commission;
- 668 (f) any other matters concerning transactions between registered insurers and any
669 affiliates as may be included in any subsequent registration forms adopted or approved by the
670 commissioner;
- 671 (g) statements that the insurer's board of directors oversees corporate governance and
672 internal controls and that the insurer's officers or senior management have approved,
673 implemented, and continue to maintain and monitor corporate governance and internal control
674 procedures; and
- 675 (h) any other information required by rule made by the commissioner in accordance
676 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

677 (3) All registration statements shall contain a summary outlining all items in the
678 current registration statement representing changes from the prior registration statement.

679 (4) No information need be disclosed on the registration statement filed pursuant to
680 Subsection (2) if the information is not material for the purposes of this section. Unless the
681 commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or
682 extensions of credit, investments, or guarantees involving one-half of 1%, or less, of an
683 insurer's admitted assets as of the next preceding December 31 may not be considered material
684 for purposes of this section.

685 (5) Subject to Section [31A-16-106](#), each registered insurer shall report to the
686 commissioner a dividend or other distribution to shareholders within 15 business days
687 following the declaration of the dividend or distribution.

688 (6) Any person within an insurance holding company system subject to registration
689 shall provide complete and accurate information to an insurer if the information is reasonably
690 necessary to enable the insurer to comply with the provisions of this chapter.

691 (7) The commissioner shall terminate the registration of any insurer which
692 demonstrates that it no longer is a member of an insurance holding company system.

693 (8) The commissioner may require or allow two or more affiliated insurers subject to
694 registration under this section to file a consolidated registration statement.

695 (9) The commissioner may allow an insurer which is authorized to do business in this
696 state, and which is part of an insurance holding company system, to register on behalf of any
697 affiliated insurer which is required to register under Subsection (1) and to file all information
698 and material required to be filed under this section.

699 (10) This section does not apply to any insurer, information, or transaction if, and to
700 the extent that, the commissioner by rule or order exempts the insurer from this section.

701 (11) Any person may file with the commissioner a disclaimer of affiliation with any
702 authorized insurer, or a disclaimer of affiliation may be filed by any insurer or any member of
703 an insurance holding company system. The disclaimer shall fully disclose all material

704 relationships and bases for affiliation between the person and the insurer as well as the basis for
705 disclaiming the affiliation. A disclaimer of affiliation is considered to have been granted
706 unless the commissioner, within 30 days following receipt of a complete disclaimer, notifies
707 the filing party the disclaimer is disallowed. If disallowed, the disclaiming party may request
708 an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its
709 duty to register under this section if approval of the disclaimer is granted by the commissioner,
710 or if the disclaimer is considered to have been approved.

711 (12) The ultimate controlling person of an insurer subject to registration shall also file
712 an annual enterprise risk report. The annual enterprise risk report shall, to the best of the
713 ultimate controlling person's knowledge and belief, identify the material risks within the
714 insurance holding company that could pose enterprise risk to the insurer. The annual enterprise
715 risk report shall be filed with the lead state commissioner of the insurance holding company
716 system as determined by the procedures within the Financial Analysis Handbook adopted by
717 the National Association of Insurance Commissioners.

718 (13) The failure to file a registration statement or any summary of the registration
719 statement or enterprise risk filing required by this section within the time specified for the
720 filing is a violation of this section.

721 Section 11. Section **31A-16a-101** is enacted to read:

722 **CHAPTER 16a. RISK MANAGEMENT AND OWN RISK AND**
723 **SOLVENCY ASSESSMENT ACT**

724 **31A-16a-101. Title -- Scope.**

725 (1) This chapter is known as the "Risk Management and Own Risk and Solvency
726 Assessment Act."

727 (2) This chapter applies to an insurer domiciled in this state unless exempt pursuant to
728 Section 31A-16a-106.

729 Section 12. Section **31A-16a-102** is enacted to read:

730 **31A-16a-102. Definitions.**

731 As used in this chapter:

732 (1) "Insurance group," for the purpose of conducting an own risk and solvency
733 assessment, means those insurers and affiliates included within an insurance holding company
734 system as defined in Section 31A-1-301.

735 (2) "Insurer" means the same as that term is defined in Section 31A-1-301, except that
736 it does not include agency, authority, or instrumentality of the United States, its possessions
737 and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or
738 political subdivision of a state.

739 (3) "ORSA guidance manual" means the current version of the Own Risk and Solvency
740 Assessment Guidance Manual developed and adopted by the National Association of Insurance
741 Commissioners and as amended from time to time.

742 (4) "ORSA summary report" means a confidential high-level summary of an insurer or
743 insurance group's own risk and solvency assessment.

744 (5) "Own risk and solvency assessment" means a confidential internal assessment,
745 appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by
746 that insurer or insurance group, of the material and relevant risks associated with the insurer or
747 insurance group's current business plan and the sufficiency of capital resources to support those
748 risks.

749 Section 13. Section **31A-16a-103** is enacted to read:

750 **31A-16a-103. Risk management framework.**

751 An insurer shall maintain a risk management framework to assist the insurer with
752 identifying, assessing, monitoring, managing, and reporting on its material and relevant risks.

753 This requirement may be satisfied if the insurance group of which the insurer is a member
754 maintains a risk management framework applicable to the operations of the insurer.

755 Section 14. Section **31A-16a-104** is enacted to read:

756 **31A-16a-104. Own risk and solvency assessment requirement.**

757 Subject to Section 31A-16a-106, an insurer, or the insurance group of which the insurer

758 is a member, shall regularly conduct an own risk and solvency assessment consistent with a
759 process comparable to the ORSA guidance manual. The insurer or insurance group shall
760 conduct the own risk and solvency assessment no less than annually but also at any time when
761 there are significant changes to the risk profile of the insurer or the insurance group of which
762 the insurer is a member.

763 Section 15. Section **31A-16a-105** is enacted to read:

764 **31A-16a-105. ORSA summary report.**

765 (1) (a) Upon the commissioner's request, and no more than once each year, an insurer
766 shall submit to the commissioner an ORSA summary report or any combination of reports that
767 together contain the information described in the ORSA guidance manual, applicable to the
768 insurer, the insurance group of which it is a member, or both.

769 (b) Notwithstanding a request from the commissioner, if the insurer is a member of an
770 insurance group, the insurer shall submit the one or more reports required by this Subsection
771 (1) if the commissioner is the lead state commissioner of the insurance group as determined by
772 the procedures within the Financial Analysis Handbook adopted by the National Association of
773 Insurance Commissioners.

774 (2) The one or more reports required under Subsection (1) shall include a signature of
775 the insurer's or insurance group's chief risk officer or other executive having responsibility for
776 the oversight of the insurer's enterprise risk management process attesting to the best of the
777 executive's belief and knowledge that:

778 (a) the insurer applies the enterprise risk management process described in the ORSA
779 summary report; and

780 (b) a copy of the report has been provided to the insurer's board of directors or the
781 appropriate committee of the board of directors.

782 (3) An insurer may comply with Subsection (1) by providing the most recent and
783 substantially similar one or more reports provided by the insurer or another member of an
784 insurance group of which the insurer is a member to the commissioner of another state or to a

785 supervisor or regulator of a foreign jurisdiction, if that report provides information that is
786 comparable to the information described in the ORSA guidance manual. A report that is in a
787 language other than English must be accompanied by a translation of that report into the
788 English language.

789 Section 16. Section **31A-16a-106** is enacted to read:

790 **31A-16a-106. Exemption.**

791 (1) An insurer shall be exempt from the requirements of this chapter, if:

792 (a) the insurer has annual direct written and unaffiliated assumed premium, including
793 international direct and assumed premium, but excluding premiums reinsured with the Federal
794 Crop Insurance Corporation and Federal Flood Program, less than \$500,000,000; and

795 (b) the insurance group of which the insurer is a member has annual direct written and
796 unaffiliated assumed premium, including international direct and assumed premium, but
797 excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood
798 Program, less than \$1,000,000,000.

799 (2) If an insurer qualifies for exemption pursuant to Subsection (1)(a), but the
800 insurance group of which the insurer is a member does not qualify for exemption pursuant to
801 Subsection (1)(b), the ORSA summary report that is required pursuant to Section [31A-16a-105](#)
802 shall include every insurer within the insurance group. This requirement may be satisfied by the
803 submission of more than one ORSA summary report for any combination of insurers provided
804 any combination of reports includes every insurer within the insurance group.

805 (3) If an insurer does not qualify for exemption pursuant to Subsection (1)(a), but the
806 insurance group of which it is a member qualifies for exemption pursuant to Subsection (1)(b),
807 the only ORSA summary report that may be required pursuant Section [31A-16a-105](#) shall be
808 the report applicable to that insurer.

809 (4) An insurer that does not qualify for exemption pursuant to Subsection (1) may
810 apply to the commissioner for a waiver from the requirements of this chapter based upon
811 unique circumstances. In deciding whether to grant the insurer's request for waiver, the

812 commissioner may consider the type and volume of business written, ownership and
813 organizational structure, and any other factor the commissioner considers relevant to the
814 insurer or insurance group of which the insurer is a member. If the insurer is part of an
815 insurance group with insurers domiciled in more than one state, the commissioner shall
816 coordinate with the lead state commissioner and with the other domiciliary commissioners in
817 considering whether to grant the insurer's request for a waiver.

818 (5) Notwithstanding the exemptions stated in this section:

819 (a) the commissioner may require that an insurer maintain a risk management
820 framework, conduct an own risk and solvency assessment, and file an ORSA summary report
821 based on unique circumstances, including the type and volume of business written, ownership
822 and organizational structure, federal agency requests, and international supervisor requests; or

823 (b) the commissioner may require that an insurer maintain a risk management
824 framework, conduct an own risk and solvency assessment and file an ORSA summary report if
825 the insurer has risk-based capital for company action level event as set forth in Sections
826 31A-17-601 through 31A-17-613, meets one or more of the standards of an insurer considered
827 to be in hazardous financial condition as defined in Section 31A-27a-101, or otherwise exhibits
828 qualities of a troubled insurer as determined by the commissioner.

829 (6) If an insurer that qualifies for an exemption pursuant to Subsection (1)
830 subsequently no longer qualifies for that exemption due to changes in premium as reflected in
831 the insurer's most recent annual statement or in the most recent annual statements of the
832 insurers within the insurance group of which the insurer is a member, the insurer has one
833 calendar year following the calendar year the threshold is exceeded to comply with the
834 requirements of this chapter.

835 Section 17. Section **31A-16a-107** is enacted to read:

836 **31A-16a-107. Contents of ORSA summary report.**

837 (1) The ORSA summary report shall be prepared consistent with the ORSA guidance
838 manual, subject to the requirements of Subsection (2). Documentation supporting information

839 shall be maintained and made available upon examination or upon request of the
840 commissioner.

841 (2) The review of the ORSA summary report, and any additional requests for
842 information, shall be made using similar procedures as used in the analysis and examination of
843 multi-state or global insurers and insurance groups.

844 Section 18. Section **31A-16a-108** is enacted to read:

845 **31A-16a-108. Confidentiality.**

846 (1) (a) A document, material, or other information, including the ORSA summary
847 report, in the possession of or control of the department that is obtained by, created by, or
848 disclosed to the commissioner or any other person under this chapter, is recognized by this state
849 as being proprietary and to contain trade secrets. The document, material, or other information
850 is confidential and may not be subject to Title 63G, Chapter 2, Government Records Access
851 and Management Act, and may not be made public by the commissioner or any other person
852 without the permission of the insurer.

853 (b) Notwithstanding Subsection (1)(a), the commissioner may use a document,
854 material, or other information in furtherance of any regulatory or legal action brought as a part
855 of the official duties. The commissioner may not otherwise make the document, material, or
856 other information public without the prior written consent of the insurer.

857 (2) The commissioner and any person who receives a document, material, or other
858 information related to an own risk and solvency assessment, through examination or otherwise,
859 while acting under the authority of the commissioner or with whom the document, material, or
860 other information is shared pursuant to this chapter shall keep the document, material, or other
861 information confidential.

862 (3) To assist in the performance of the commissioner's regulatory duties, the
863 commissioner:

864 (a) may, upon request, share a document, material, or other information related to an
865 own risk solvency assessment, including a confidential document, material, or information

866 subject to Subsection (1), including proprietary and trade secret documents and materials with
867 other state, federal, and international financial regulatory agencies, including members of any
868 supervisory college as described in the Section [31A-16-108.5](#), with the National Association of
869 Insurance Commissioners and with any third-party consultants designated by the
870 commissioner, provided that the recipient agrees in writing to maintain the confidentiality of
871 documents, materials, or other information related to an own risk and solvency assessment and
872 has verified in writing the legal authority to maintain confidentiality;

873 (b) may receive a document, material, or other information related to an own risk and
874 solvency assessment, including an otherwise confidential document, material, or information,
875 including proprietary and trade secret information or documents, from regulatory officials of
876 other foreign or domestic jurisdictions, including members of any supervisory college as
877 described in Section [31A-16-108.5](#) and from the National Association of Insurance
878 Commissioners, and shall maintain as confidential a document, material, or information
879 received with notice or the understanding that the document, material, or information is
880 confidential under the laws of the jurisdiction that is the source of the document, material, or
881 information; and

882 (c) shall enter into a written agreement with the National Association of Insurance
883 Commissioners or a third-party consultant governing sharing and use of information provided
884 pursuant to this chapter, consistent with this Subsection (3) that shall:

885 (i) specify procedures and protocols regarding the confidentiality and security of
886 information shared with the National Association of Insurance Commissioners or a third-party
887 consultant pursuant to this chapter, including procedures and protocols for sharing by the
888 National Association of Insurance Commissioners with other state regulators from states in
889 which the insurance group has domiciled insurers with the agreement providing that the
890 recipient agrees in writing to maintain the confidentiality of a document, material, or other
891 information related to an own risk and solvency assessment and verifies in writing the legal
892 authority to maintain confidentiality;

893 (ii) specify that ownership of information shared with the National Association of
894 Insurance Commissioners or a third-party consultant pursuant to this chapter remains with the
895 commissioner, and that the National Association of Insurance Commissioners' or a third-party
896 consultant's use of the information is subject to the direction of the commissioner;

897 (iii) prohibit the National Association of Insurance Commissioners or third-party
898 consultant from storing the information shared pursuant to this chapter in a permanent database
899 after the underlying analysis is completed;

900 (iv) require prompt notice to be given to an insurer whose confidential information in
901 the possession of the National Association of Insurance Commissioners or a third-party
902 consultant pursuant to this chapter is subject to a request or subpoena to the National
903 Association of Insurance Commissioners or a third-party consultant for disclosure or
904 production;

905 (v) require the National Association of Insurance Commissioners or a third-party
906 consultant to consent to intervention by an insurer in any judicial or administrative action in
907 which the National Association of Insurance Commissioners or a third-party consultant may be
908 required to disclose confidential information about the insurer shared with the National
909 Association of Insurance Commissioners or a third-party consultant pursuant to this chapter;
910 and

911 (vi) in the case of an agreement involving a third-party consultant, provide for the
912 insurer's written consent.

913 (4) The sharing of information or a document by the commissioner pursuant to this
914 chapter does not constitute a delegation of regulatory authority or rulemaking, and the
915 commissioner is solely responsible for the administration, execution, and enforcement of this
916 chapter.

917 (5) A waiver of an applicable claim of confidentiality in a document, proprietary and
918 trade-secret material, or other information related to an own risk and solvency assessment may
919 not occur as a result of disclosure of the own risk and solvency assessment related information

920 or a document to the commissioner under this section or as a result of sharing as authorized in
 921 this chapter.

922 (6) A document, material, or other information in the possession or control of the
 923 National Association of Insurance Commissioners or a third-party consultant pursuant to this
 924 chapter is:

- 925 (a) confidential, not a public record, and not open to public inspection; and
- 926 (b) not subject to Title 63G, Chapter 2, Government Records Access and Management
 927 Act.

928 Section 19. Section **31A-16a-109** is enacted to read:

929 **31A-16a-109. Sanctions.**

930 An insurer failing, without just cause, to timely file the ORSA summary report as
 931 required in this chapter is required, after notice and hearing, is subject to a penalty under
 932 Section [31A-2-308](#) for each day's delay, to be recovered by the commissioner and the penalty
 933 so recovered shall be paid into the General Fund. The maximum penalty under this section is a
 934 penalty permitted under Section [31A-2-308](#). The commissioner may reduce the penalty if the
 935 insurer demonstrates to the commissioner that the imposition of the penalty would constitute a
 936 financial hardship to the insurer.

937 Section 20. Section **31A-16a-110** is enacted to read:

938 **31A-16a-110. Severability Clause.**

939 If a provision of this chapter, or the application of this chapter to any person or
 940 circumstance, is held invalid, the invalidation does not affect the provisions or applications of
 941 this chapter that can be given effect without the invalid provision or application, and to that end
 942 the provisions of this chapter are severable.

943 Section 21. Section **31A-17-404** is amended to read:

944 **31A-17-404. Credit allowed a domestic ceding insurer against reserves for**
 945 **reinsurance.**

946 (1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a

947 reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of
948 Subsection (3), (4), (5), (6), (7), or (8), subject to the following:

949 (a) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a
950 kind or class of business that the assuming insurer is licensed or otherwise permitted to write or
951 assume:

952 (i) in its state of domicile; or

953 (ii) in the case of a United States branch of an alien assuming insurer, in the state
954 through which it is entered and licensed to transact insurance or reinsurance.

955 (b) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of
956 Subsection (9) are met.

957 (2) A domestic ceding insurer is allowed credit for reinsurance ceded:

958 (a) only if the reinsurance is payable in a manner consistent with Section [31A-22-1201](#);

959 (b) only to the extent that the accounting:

960 (i) is consistent with the terms of the reinsurance contract; and

961 (ii) clearly reflects:

962 (A) the amount and nature of risk transferred; and

963 (B) liability, including contingent liability, of the ceding insurer;

964 (c) only to the extent the reinsurance contract shifts insurance policy risk from the
965 ceding insurer to the assuming reinsurer in fact and not merely in form; and

966 (d) only if the reinsurance contract contains a provision placing on the reinsurer the
967 credit risk of all dealings with intermediaries regarding the reinsurance contract.

968 (3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
969 assuming insurer that is licensed to transact insurance or reinsurance in this state.

970 (4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
971 assuming insurer that is accredited by the commissioner as a reinsurer in this state.

972 (b) An insurer is accredited as a reinsurer if the insurer:

973 (i) files with the commissioner evidence of the insurer's submission to this state's

974 jurisdiction;

975 (ii) submits to the commissioner's authority to examine the insurer's books and records;

976 (iii) (A) is licensed to transact insurance or reinsurance in at least one state; or

977 (B) in the case of a United States branch of an alien assuming insurer, is entered

978 through and licensed to transact insurance or reinsurance in at least one state;

979 (iv) files annually with the commissioner a copy of the insurer's:

980 (A) annual statement filed with the insurance department of its state of domicile; and

981 (B) most recent audited financial statement; and

982 (v) (A) (I) has not had its accreditation denied by the commissioner within 90 days of

983 the day on which the insurer submits the information required by this Subsection (4); and

984 (II) maintains a surplus with regard to policyholders in an amount not less than

985 \$20,000,000; or

986 (B) (I) has its accreditation approved by the commissioner; and

987 (II) maintains a surplus with regard to policyholders in an amount less than

988 \$20,000,000.

989 (c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's

990 accreditation is revoked by the commissioner after a notice and hearing.

991 (5) (a) A domestic ceding insurer is allowed a credit if:

992 (i) the reinsurance is ceded to an assuming insurer that is:

993 (A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or

994 (B) in the case of a United States branch of an alien assuming insurer, is entered

995 through a state meeting the requirements of Subsection (5)(a)(ii);

996 (ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for

997 reinsurance substantially similar to those applicable under this section; and

998 (iii) the assuming insurer or United States branch of an alien assuming insurer:

999 (A) maintains a surplus with regard to policyholders in an amount not less than

1000 \$20,000,000; and

- 1001 (B) submits to the authority of the commissioner to examine its books and records.
- 1002 (b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded
1003 and assumed pursuant to a pooling arrangement among insurers in the same holding company
1004 system.
- 1005 (6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
1006 assuming insurer that maintains a trust fund:
- 1007 (i) created in accordance with rules made by the commissioner pursuant to Title 63G,
1008 Chapter 3, Utah Administrative Rulemaking Act; and
- 1009 (ii) in a qualified United States financial institution for the payment of a valid claim of:
- 1010 (A) a United States ceding insurer of the assuming insurer;
- 1011 (B) an assign of the United States ceding insurer; and
- 1012 (C) a successor in interest to the United States ceding insurer.
- 1013 (b) To enable the commissioner to determine the sufficiency of the trust fund described
1014 in Subsection (6)(a), the assuming insurer shall:
- 1015 (i) report annually to the commissioner information substantially the same as that
1016 required to be reported on the National Association of Insurance Commissioners Annual
1017 Statement form by a licensed insurer; and
- 1018 (ii) (A) submit to examination of its books and records by the commissioner; and
1019 (B) pay the cost of an examination.
- 1020 (c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the
1021 form of the trust and any amendment to the trust is approved by:
- 1022 (A) the commissioner of the state where the trust is domiciled; or
1023 (B) the commissioner of another state who, pursuant to the terms of the trust
1024 instrument, accepts principal regulatory oversight of the trust.
- 1025 (ii) The form of the trust and an amendment to the trust shall be filed with the
1026 commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.
- 1027 (iii) The trust instrument shall provide that a contested claim is valid and enforceable

1028 upon the final order of a court of competent jurisdiction in the United States.

1029 (iv) The trust shall vest legal title to its assets in its one or more trustees for the benefit

1030 of:

1031 (A) a United States ceding insurer of the assuming insurer;

1032 (B) an assign of the United States ceding insurer; or

1033 (C) a successor in interest to the United States ceding insurer.

1034 (v) The trust and the assuming insurer are subject to examination as determined by the

1035 commissioner.

1036 (vi) The trust shall remain in effect for as long as the assuming insurer has an

1037 outstanding obligation due under a reinsurance agreement subject to the trust.

1038 (vii) No later than February 28 of each year, the trustee of the trust shall:

1039 (A) report to the commissioner in writing the balance of the trust;

1040 (B) list the trust's investments at the end of the preceding calendar year; and

1041 (C) (I) certify the date of termination of the trust, if so planned; or

1042 (II) certify that the trust will not expire prior to the following December 31.

1043 (d) The following requirements apply to the following categories of assuming insurer:

1044 (i) For a single assuming insurer:

1045 (A) the trust fund shall consist of funds in trust in an amount not less than the assuming

1046 insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and

1047 (B) the assuming insurer shall maintain a trusteed surplus of not less than \$20,000,000,

1048 except as provided in Subsection (6)(d)(ii).

1049 (ii) (A) At any time after the assuming insurer has permanently discontinued

1050 underwriting new business secured by the trust for at least three full years, the commissioner

1051 with principal regulatory oversight of the trust may authorize a reduction in the required

1052 trusteed surplus, but only after a finding, based on an assessment of the risk, that the new

1053 required surplus level is adequate for the protection of United States ceding insurers,

1054 policyholders, and claimants in light of reasonably foreseeable adverse loss development.

1055 (B) The risk assessment may involve an actuarial review, including an independent
1056 analysis of reserves and cash flows, and shall consider all material risk factors, including, when
1057 applicable, the lines of business involved, the stability of the incurred loss estimates, and the
1058 effect of the surplus requirements on the assuming insurer's liquidity or solvency.

1059 (C) The minimum required trusteed surplus may not be reduced to an amount less than
1060 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States
1061 ceding insurers covered by the trust.

1062 (iii) For a group acting as assuming insurer, including incorporated and individual
1063 unincorporated underwriters:

1064 (A) for reinsurance ceded under a reinsurance agreement with an inception,
1065 amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed
1066 account in an amount not less than the respective underwriters' several liabilities attributable to
1067 business ceded by the one or more United States domiciled ceding insurers to an underwriter of
1068 the group;

1069 (B) for reinsurance ceded under a reinsurance agreement with an inception date on or
1070 before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the
1071 other provisions of this chapter, the trust shall consist of a trusteed account in an amount not
1072 less than the respective underwriters' several insurance and reinsurance liabilities attributable to
1073 business written in the United States;

1074 (C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall
1075 maintain in trust a trusteed surplus of which \$100,000,000 is held jointly for the benefit of the
1076 one or more United States domiciled ceding insurers of a member of the group for all years of
1077 account;

1078 (D) the incorporated members of the group:

1079 (I) may not be engaged in a business other than underwriting as a member of the group;

1080 and

1081 (II) are subject to the same level of regulation and solvency control by the group's

1082 domiciliary regulator as are the unincorporated members; and

1083 (E) within 90 days after the day on which the group's financial statements are due to be
1084 filed with the group's domiciliary regulator, the group shall provide to the commissioner:

1085 (I) an annual certification by the group's domiciliary regulator of the solvency of each
1086 underwriter member; or

1087 (II) if a certification is unavailable, a financial statement, prepared by an independent
1088 public accountant, of each underwriter member of the group.

1089 (iv) For a group of incorporated underwriters under common administration, the group
1090 shall:

1091 (A) have continuously transacted an insurance business outside the United States for at
1092 least three years immediately preceding the day on which the group makes application for
1093 accreditation;

1094 (B) maintain aggregate policyholders' surplus of at least \$10,000,000,000;

1095 (C) maintain a trust fund in an amount not less than the group's several liabilities
1096 attributable to business ceded by the one or more United States domiciled ceding insurers to a
1097 member of the group pursuant to a reinsurance contract issued in the name of the group;

1098 (D) in addition to complying with the other provisions of this Subsection (6)(d)(iv),
1099 maintain a joint trusteed surplus of which \$100,000,000 is held jointly for the benefit of the one
1100 or more United States domiciled ceding insurers of a member of the group as additional
1101 security for these liabilities; and

1102 (E) within 90 days after the day on which the group's financial statements are due to be
1103 filed with the group's domiciliary regulator, make available to the commissioner:

1104 (I) an annual certification of each underwriter member's solvency by the member's
1105 domiciliary regulator; and

1106 (II) a financial statement of each underwriter member of the group prepared by an
1107 independent public accountant.

1108 (7) If reinsurance is ceded to an assuming insurer not meeting the requirements of

1109 Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the
1110 insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law
1111 or regulation of that jurisdiction.

1112 (8) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
1113 assuming insurer that secures its obligations in accordance with this Subsection (8):

1114 (a) The insurer shall be certified by the commissioner as a reinsurer in this state.

1115 (b) To be eligible for certification, the assuming insurer shall:

1116 (i) be domiciled and licensed to transact insurance or reinsurance in a qualified
1117 jurisdiction, as determined by the commissioner pursuant to Subsection (8)(d);

1118 (ii) maintain minimum capital and surplus, or its equivalent, in an amount to be
1119 determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter
1120 3, Utah Administrative Rulemaking Act;

1121 (iii) maintain financial strength ratings from two or more rating agencies considered
1122 acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter
1123 3, Utah Administrative Rulemaking Act; and

1124 (iv) agree to:

1125 (A) submit to the jurisdiction of this state;

1126 (B) appoint the commissioner as its agent for service of process in this state;

1127 (C) provide security for 100% of the assuming insurer's liabilities attributable to
1128 reinsurance ceded by United States ceding insurers if it resists enforcement of a final United
1129 States judgment;

1130 (D) agree to meet applicable information filing requirements as determined by the
1131 commissioner including an application for certification, a renewal and on an ongoing basis; and

1132 (E) any other requirements for certification considered relevant by the commissioner.

1133 (c) An association, including incorporated and individual unincorporated underwriters,
1134 may be a certified reinsurer. To be eligible for certification, in addition to satisfying
1135 requirements of Subsections (8)(a) and (b), the association:

1136 (i) shall satisfy its minimum capital and surplus requirements through the capital and
1137 surplus equivalents, net of liabilities, of the association and its members, which shall include a
1138 joint central fund that may be applied to any unsatisfied obligation of the association or any of
1139 its members in an amount determined by the commissioner to provide adequate protection;

1140 (ii) may not have incorporated members of the association engaged in any business
1141 other than underwriting as a member of the association;

1142 (iii) shall be subject to the same level of regulation and solvency control of the
1143 incorporated members of the association by the association's domiciliary regulator as are the
1144 unincorporated members; and

1145 (iv) within 90 days after its financial statements are due to be filed with the
1146 association's domiciliary regulator provide:

1147 (A) to the commissioner an annual certification by the association's domiciliary
1148 regulator of the solvency of each underwriter member; or

1149 (B) if a certification is unavailable, financial statements prepared by independent
1150 public accountants, of each underwriter member of the association.

1151 (d) The commissioner shall create and publish a list of qualified jurisdictions under
1152 which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be
1153 considered for certification by the commissioner as a certified reinsurer.

1154 (i) To determine whether the domiciliary jurisdiction of a non-United States assuming
1155 insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:

1156 (A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory
1157 system of the jurisdiction, both initially and on an ongoing basis;

1158 (B) shall consider the rights, the benefits, and the extent of reciprocal recognition
1159 afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the
1160 United States;

1161 (C) shall require the qualified jurisdiction to share information and cooperate with the
1162 commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and

1163 (D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has
1164 determined that the jurisdiction does not adequately and promptly enforce final United States
1165 judgments and arbitration awards.

1166 (ii) The commissioner may consider additional factors in determining a qualified
1167 jurisdiction.

1168 (iii) A list of qualified jurisdictions shall be published through the National
1169 Association of Insurance Commissioners' Committee Process and the commissioner shall:

1170 (A) consider this list in determining qualified jurisdictions; and

1171 (B) if the commissioner approves a jurisdiction as qualified that does not appear on the
1172 National Association of Insurance Commissioner's list of qualified jurisdictions, provide
1173 thoroughly documented justification in accordance with criteria to be developed by rule made
1174 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

1175 (iv) United States jurisdictions that meet the requirement for accreditation under the
1176 National Association of Insurance Commissioners' financial standards and accreditation
1177 program shall be recognized as qualified jurisdictions.

1178 (v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction,
1179 the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.

1180 (e) The commissioner shall:

1181 (i) assign a rating to each certified reinsurer, giving due consideration to the financial
1182 strength ratings that have been assigned by rating agencies considered acceptable to the
1183 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
1184 Rulemaking Act; and

1185 (ii) publish a list of all certified reinsurers and their ratings.

1186 (f) A certified reinsurer shall secure obligations assumed from United States ceding
1187 insurers under this Subsection (8) at a level consistent with its rating, as specified in rules made
1188 by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative
1189 Rulemaking Act.

1190 (i) For a domestic ceding insurer to qualify for full financial statement credit for
1191 reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a
1192 form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a
1193 multibeneficiary trust in accordance with Subsections (5), (6), and (7), except as otherwise
1194 provided in this Subsection (8).

1195 (ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to
1196 Subsections (5), (6), and (7), and chooses to secure its obligations incurred as a certified
1197 reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate
1198 trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a
1199 certified reinsurer with reduced security as permitted by this Subsection (8) or comparable laws
1200 of other United States jurisdictions and for its obligations subject to Subsections (5), (6), and
1201 (7).

1202 (iii) It shall be a condition to the grant of certification under this Subsection (8) that the
1203 certified reinsurer shall have bound itself[;]:

1204 (A) by the language of the trust and agreement with the commissioner with principal
1205 regulatory oversight of the trust account[;]; and

1206 (B) upon termination of the trust account, to fund, [~~upon termination of the trust~~
1207 ~~account,~~] out of the remaining surplus of the trust, any deficiency of any other [~~the~~] trust
1208 account.

1209 (iv) The minimum trustee surplus requirements provided in Subsections (5), (6), and
1210 (7) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer
1211 for the purpose of securing obligations incurred under this Subsection (8), except that the trust
1212 shall maintain a minimum trustee surplus of \$10,000,000.

1213 (v) With respect to obligations incurred by a certified reinsurer under this Subsection
1214 (8), if the security is insufficient, the commissioner:

1215 (A) shall reduce the allowable credit by an amount proportionate to the deficiency; and

1216 (B) may impose further reductions in allowable credit upon finding that there is a

1217 material risk that the certified reinsurer's obligations will not be paid in full when due.

1218 (vi) For purposes of this Subsection (8), a certified reinsurer whose certification has
1219 been terminated for any reason shall be treated as a certified reinsurer required to secure 100%
1220 of its obligations.

1221 (A) As used in this Subsection (8), the term "terminated" refers to revocation,
1222 suspension, voluntary surrender, and inactive status.

1223 (B) If the commissioner continues to assign a higher rating as permitted by other
1224 provisions of this section, the requirement under this Subsection (8)(f)(vi) does not apply to a
1225 certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

1226 (g) If an applicant for certification has been certified as a reinsurer in a National
1227 Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:

1228 (i) defer to that jurisdiction's certification;

1229 (ii) defer to the rating assigned by that jurisdiction; and

1230 (iii) consider such reinsurer to be a certified reinsurer in this state.

1231 (h) (i) A certified reinsurer that ceases to assume new business in this state may request
1232 to maintain its certification in inactive status in order to continue to qualify for a reduction in
1233 security for its in-force business.

1234 (ii) An inactive certified reinsurer shall continue to comply with all applicable
1235 requirements of this Subsection (8).

1236 (iii) The commissioner shall assign a rating to a reinsurer that qualifies under this
1237 Subsection (8)(h), that takes into account, if relevant, the reasons why the reinsurer is not
1238 assuming new business.

1239 (9) Reinsurance credit may not be allowed a domestic ceding insurer unless the
1240 assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

1241 (a) (i) being an admitted insurer; and

1242 (ii) submitting to jurisdiction under Section [31A-2-309](#);

1243 (b) having irrevocably appointed the commissioner as the domestic ceding insurer's

1244 agent for service of process in an action arising out of or in connection with the reinsurance,
1245 which appointment is made under Section 31A-2-309; or

1246 (c) agreeing in the reinsurance contract:

1247 (i) that if the assuming insurer fails to perform its obligations under the terms of the
1248 reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

1249 (A) submit to the jurisdiction of a court of competent jurisdiction in a state of the
1250 United States;

1251 (B) comply with all requirements necessary to give the court jurisdiction; and

1252 (C) abide by the final decision of the court or of an appellate court in the event of an
1253 appeal; and

1254 (ii) to designate the commissioner or a specific attorney licensed to practice law in this
1255 state as its attorney upon whom may be served lawful process in an action, suit, or proceeding
1256 instituted by or on behalf of the ceding company.

1257 (10) Submitting to the jurisdiction of Utah courts under Subsection (9) does not
1258 override a duty or right of a party under the reinsurance contract, including a requirement that
1259 the parties arbitrate their disputes.

1260 (11) If an assuming insurer does not meet the requirements of Subsection (3), (4), or
1261 (5), the credit permitted by Subsection (6) or (8) may not be allowed unless the assuming
1262 insurer agrees in the trust instrument to the following conditions:

1263 (a) (i) Notwithstanding any other provision in the trust instrument, if an event
1264 described in Subsection (11)(a)(ii) occurs the trustee shall comply with:

1265 (A) an order of the commissioner with regulatory oversight over the trust; or

1266 (B) an order of a court of competent jurisdiction directing the trustee to transfer to the
1267 commissioner with regulatory oversight all of the assets of the trust fund.

1268 (ii) This Subsection (11)(a) applies if:

1269 (A) the trust fund is inadequate because the trust contains an amount less than the
1270 amount required by Subsection (6)(d); or

1271 (B) the grantor of the trust is:
1272 (I) declared insolvent; or
1273 (II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the
1274 laws of its state or country of domicile.

1275 (b) The assets of a trust fund described in Subsection (11)(a) shall be distributed by and
1276 a claim shall be filed with and valued by the commissioner with regulatory oversight in
1277 accordance with the laws of the state in which the trust is domiciled that are applicable to the
1278 liquidation of a domestic insurance company.

1279 (c) If the commissioner with regulatory oversight determines that the assets of the trust
1280 fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United
1281 States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be
1282 returned by the commissioner with regulatory oversight to the trustee for distribution in
1283 accordance with the trust instrument.

1284 (d) A grantor shall waive any right otherwise available to it under United States law
1285 that is inconsistent with this Subsection (11).

1286 (12) If an accredited or certified reinsurer ceases to meet the requirements for
1287 accreditation or certification, the commissioner may suspend or revoke the reinsurer's
1288 accreditation or certification.

1289 (a) The commissioner shall give the reinsurer notice and opportunity for hearing.

1290 (b) The suspension or revocation may not take effect until after the commissioner's
1291 order after a hearing, unless:

1292 (i) the reinsurer waives its right to hearing;
1293 (ii) the commissioner's order is based on:
1294 (A) regulatory action by the reinsurer's domiciliary jurisdiction; or
1295 (B) the voluntary surrender or termination of the reinsurer's eligibility to transact
1296 insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state
1297 under Subsection (8)(g); or

1298 (iii) the commissioner's finding that an emergency requires immediate action and a
1299 court of competent jurisdiction has not stayed the commissioner's action.

1300 (c) While a reinsurer's accreditation or certification is suspended, no reinsurance
1301 contract issued or renewed after the effective date of the suspension qualifies for credit except
1302 to the extent that the reinsurer's obligations under the contract are secured in accordance with
1303 Section [31A-17-404.1](#).

1304 (d) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance
1305 may be granted after the effective date of the revocation except to the extent that the reinsurer's
1306 obligations under the contract are secured in accordance with Subsection (8)(f) or Section
1307 [31A-17-404.1](#).

1308 (13) (a) A ceding insurer shall take steps to manage its reinsurance recoverables
1309 proportionate to its own book of business.

1310 (b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after
1311 reinsurance recoverables from any single assuming insurer, or group of affiliated assuming
1312 insurers:

1313 (A) exceeds 50% of the domestic ceding insurer's last reported surplus to
1314 policyholders; or

1315 (B) after it is determined that reinsurance recoverables from any single assuming
1316 insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding
1317 insurer's last reported surplus to policyholders.

1318 (ii) The notification required by Subsection (13)(b)(i) shall demonstrate that the
1319 exposure is safely managed by the domestic ceding insurer.

1320 (c) A ceding insurer shall take steps to diversify its reinsurance program.

1321 (d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after
1322 ceding or being likely to cede more than 20% of the ceding insurer's gross written premium in
1323 the prior calendar year to any:

1324 (A) single assuming insurer; or

1325 (B) group of affiliated assuming insurers.

1326 (ii) The notification shall demonstrate that the exposure is safely managed by the
1327 domestic ceding insurer.

1328 Section 22. Section **31A-17-603** is amended to read:

1329 **31A-17-603. Company action level event.**

1330 (1) "Company action level event" means any of the following events:

1331 (a) the filing of an RBC report by an insurer or health organization that indicates that:

1332 (i) the insurer's or health organization's total adjusted capital is greater than or equal to
1333 its regulatory action level RBC but less than its company action level RBC;

1334 (ii) if a life [~~or~~] insurer, accident and health insurer, or health organization, the insurer
1335 [~~has~~] or health organization:

1336 (A) has total adjusted capital that is greater than or equal to its company action level
1337 RBC but less than the product of its authorized control level RBC and 3.0; and

1338 (B) triggers the trend test determined in accordance with the trend test calculation
1339 included in the life [~~or~~], fraternal, or health RBC instructions; or

1340 (iii) if a property and casualty insurer, the insurer has:

1341 (A) total adjusted capital that is greater than or equal to its company action level RBC,
1342 but less than the product of its authorized control level RBC and 3.0; and

1343 (B) triggers the trend test determined in accordance with the trend test calculation
1344 included in the property and casualty RBC instructions;

1345 (b) the notification by the commissioner to the insurer or health organization of an
1346 adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health
1347 organization does not challenge the adjusted RBC report under Section **31A-17-607**; or

1348 (c) if, pursuant to Section **31A-17-607**, an insurer or health organization challenges an
1349 adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the
1350 commissioner to the insurer or health organization that after a hearing the commissioner rejects
1351 the insurer's or health organization's challenge.

1352 (2) (a) In the event of a company action level event, the insurer or health organization
1353 shall prepare and submit to the commissioner an RBC plan that shall:

1354 (i) identify the conditions that contribute to the company action level event;

1355 (ii) contain proposals of corrective actions that the insurer or health organization
1356 intends to take and that are expected to result in the elimination of the company action level
1357 event;

1358 (iii) provide projections of the insurer's or health organization's financial results in the
1359 current year and at least the four succeeding years, both in the absence of proposed corrective
1360 actions and giving effect to the proposed corrective actions, including projections of:

1361 (A) statutory operating income;

1362 (B) net income;

1363 (C) capital;

1364 (D) surplus; and

1365 (E) RBC levels;

1366 (iv) identify the key assumptions impacting the insurer's or health organization's
1367 projections and the sensitivity of the projections to the assumptions; and

1368 (v) identify the quality of, and problems associated with, the insurer's or health
1369 organization's business, including its assets, anticipated business growth and associated surplus
1370 strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each
1371 case.

1372 (b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal
1373 business may include separate projections for each major line of business and separately
1374 identify each significant income, expense, and benefit component.

1375 (3) The RBC plan shall be submitted:

1376 (a) within 45 days of the company action level event; or

1377 (b) if the insurer or health organization challenges an adjusted RBC report pursuant to
1378 Section [31A-17-607](#), within 45 days after notification to the insurer or health organization that

1379 after a hearing the commissioner rejects the insurer's or health organization's challenge.

1380 (4) (a) Within 60 days after the submission by an insurer or health organization of an
1381 RBC plan to the commissioner, the commissioner shall notify the insurer or health organization
1382 whether the RBC plan:

1383 (i) shall be implemented; or

1384 (ii) is unsatisfactory.

1385 (b) If the commissioner determines the RBC plan is unsatisfactory, the notification to
1386 the insurer or health organization shall set forth the reasons for the determination, and may
1387 propose revisions that will render the RBC plan satisfactory. Upon notification from the
1388 commissioner, the insurer or health organization shall:

1389 (i) prepare a revised RBC plan that incorporates any revision proposed by the
1390 commissioner; and

1391 (ii) submit the revised RBC plan to the commissioner:

1392 (A) within 45 days after the notification from the commissioner; or

1393 (B) if the insurer challenges the notification from the commissioner under Section
1394 [31A-17-607](#), within 45 days after a notification to the insurer or health organization that after a
1395 hearing the commissioner rejects the insurer's or health organization's challenge.

1396 (5) In the event of a notification by the commissioner to an insurer or health
1397 organization that the insurer's or health organization's RBC plan or revised RBC plan is
1398 unsatisfactory, the commissioner may specify in the notification that the notification constitutes
1399 a regulatory action level event subject to the insurer's or health organization's right to a hearing
1400 under Section [31A-17-607](#).

1401 (6) Every domestic insurer or health organization that files an RBC plan or revised
1402 RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with
1403 the insurance commissioner in any state in which the insurer or health organization is
1404 authorized to do business if:

1405 (a) the state has an RBC provision substantially similar to Subsection [31A-17-608\(1\)](#);

1406 and

1407 (b) the insurance commissioner of that state notifies the insurer or health organization
1408 of its request for the filing in writing, in which case the insurer or health organization shall file
1409 a copy of the RBC plan or revised RBC plan in that state no later than the later of:

1410 (i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan
1411 with that state; or

1412 (ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3)
1413 and (4).

1414 Section 23. Section 31A-22-505 is amended to read:

1415 **31A-22-505. Association groups.**

1416 (1) A policy is subject to the requirements of this section if the policy is issued as
1417 policyholder to an association or to the trustees of a fund established, created, or maintained for
1418 the benefit of members of one or more associations;

1419 (a) with a minimum membership of 100 persons^[5]₂;

1420 (b) with a constitution and bylaws^[5]~~and which~~₂;

1421 (c) having a shared or common purpose that is not primarily a business or customer
1422 relationship; and

1423 (d) that has been in active existence for at least two years^[5]~~is subject to the following~~
1424 requirements₂].

1425 ~~(1)~~ (2) The policy may insure members and employees of the association, employees
1426 of the members, one or more of the preceding entities, or all of any classes of these named
1427 entities for the benefit of persons other than the employees' employer, or any officials,
1428 representatives, trustees, or agents of the employer or association.

1429 ~~(2)~~ (3) The premiums shall be paid by the policyholder from funds contributed by the
1430 associations, by employer members, from funds contributed by the covered persons, or from
1431 any combination of these. Except as provided under Section 31A-22-512, a policy on which no
1432 part of the premium is contributed by the covered persons, specifically for their insurance, is

1433 required to insure all eligible persons.

1434 Section 24. Section **31A-22-605** is amended to read:

1435 **31A-22-605. Accident and health insurance standards.**

1436 (1) The purposes of this section include:

1437 (a) reasonable standardization and simplification of terms and coverages of individual
1438 and franchise accident and health insurance policies, including accident and health insurance
1439 contracts of insurers licensed under Chapter 7, Nonprofit Health Service Insurance

1440 Corporations, and Chapter 8, Health Maintenance Organizations and Limited Health Plans, to
1441 facilitate public understanding and comparison in purchasing;

1442 (b) elimination of provisions contained in individual and franchise accident and health
1443 insurance contracts that may be misleading or confusing in connection with either the purchase
1444 of those types of coverages or the settlement of claims; and

1445 (c) full disclosure in the sale of individual and franchise accident and health insurance
1446 contracts.

1447 (2) As used in this section:

1448 (a) "Direct response insurance policy" means an individual insurance policy solicited
1449 and sold without the policyholder having direct contact with a natural person intermediary.

1450 (b) "Medicare" means the same as that term is defined in Subsection [31A-22-620\(1\)\(e\)](#).

1451 (c) "Medicare supplement policy" means the same as that term is defined in Subsection
1452 [31A-22-620\(1\)\(f\)](#).

1453 (3) This section applies to all individual and franchise accident and health policies.

1454 (4) The commissioner shall adopt rules, made in accordance with Title 63G, Chapter 3,
1455 Utah Administrative Rulemaking Act, relating to the following matters:

1456 (a) standards for the manner and content of policy provisions, and disclosures to be
1457 made in connection with the sale of policies covered by this section, dealing with at least the
1458 following matters:

1459 (i) terms of renewability;

- 1460 (ii) initial and subsequent conditions of eligibility;
- 1461 (iii) nonduplication of coverage provisions;
- 1462 (iv) coverage of dependents;
- 1463 (v) preexisting conditions;
- 1464 (vi) termination of insurance;
- 1465 (vii) probationary periods;
- 1466 (viii) limitations;
- 1467 (ix) exceptions;
- 1468 (x) reductions;
- 1469 (xi) elimination periods;
- 1470 (xii) requirements for replacement;
- 1471 (xiii) recurrent conditions;
- 1472 (xiv) coverage of persons eligible for Medicare; and
- 1473 (xv) definition of terms;
- 1474 (b) minimum standards for benefits under each of the following categories of coverage
- 1475 in policies covered in this section:
 - 1476 (i) basic hospital expense coverage;
 - 1477 (ii) basic medical-surgical expense coverage;
 - 1478 (iii) hospital confinement indemnity coverage;
 - 1479 (iv) major medical expense coverage;
 - 1480 (v) income replacement coverage;
 - 1481 (vi) accident only coverage;
 - 1482 (vii) specified disease or specified accident coverage;
 - 1483 (viii) limited benefit health coverage; and
 - 1484 (ix) nursing home and long-term care coverage;
- 1485 (c) the content and format of the outline of coverage, in addition to that required under
- 1486 Subsection (6);

1487 (d) the method of identification of policies and contracts based upon coverages
1488 provided; and

1489 (e) rating practices.

1490 (5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine
1491 categories of coverage in ~~[that subsection]~~ Subsection (4)(b) provided that any combination of
1492 categories meets the standards of a component category of coverage.

1493 (6) The commissioner may adopt rules, made in accordance with Title 63G, Chapter 3,
1494 Utah Administrative Rulemaking Act, relating to the following matters:

1495 (a) establishing disclosure requirements for insurance policies covered in this section,
1496 designed to adequately inform the prospective insured of the need for and extent of the
1497 coverage offered, and requiring that this disclosure be furnished to the prospective insured with
1498 the application form, unless it is a direct response insurance policy;

1499 (b) (i) prescribing caption or notice requirements designed to inform prospective
1500 insureds that particular insurance coverages are not Medicare Supplement coverages;

1501 (ii) the requirements of Subsection (6)(b)(i) apply to all insurance policies and
1502 certificates sold to persons eligible for Medicare; and

1503 (c) requiring the disclosures or information brochures to be furnished to the
1504 prospective insured on direct response insurance policies, upon his request or, in any event, no
1505 later than the time of the policy delivery.

1506 (7) A policy covered by this section may be issued only if it meets the minimum
1507 standards established by the commissioner under Subsection (4), an outline of coverage
1508 accompanies the policy or is delivered to the applicant at the time of the application, and,
1509 except with respect to direct response insurance policies, an acknowledged receipt is provided
1510 to the insurer. The outline of coverage shall include:

1511 (a) a statement identifying the applicable categories of coverage provided by the policy
1512 as prescribed under Subsection (4);

1513 (b) a description of the principal benefits and coverage;

- 1514 (c) a statement of the exceptions, reductions, and limitations contained in the policy;
- 1515 (d) a statement of the renewal provisions, including any reservation by the insurer of a
- 1516 right to change premiums;
- 1517 (e) a statement that the outline is a summary of the policy issued or applied for and that
- 1518 the policy should be consulted to determine governing contractual provisions; and
- 1519 (f) any other contents the commissioner prescribes.

1520 (8) If a policy is issued on a basis other than that applied for, the outline of coverage

1521 shall accompany the policy when it is delivered and it shall clearly state that it is not the policy

1522 for which application was made.

1523 (9) (a) Notwithstanding Subsection 31A-22-606(1), limited accident and health

1524 policies or certificates issued to persons eligible for Medicare shall contain a notice

1525 prominently printed on or attached to the cover or front page which states that the policyholder

1526 or certificate holder has the right to return the policy for any reason within 30 days after its

1527 delivery and to have the premium refunded.

1528 (b) This Subsection (9) does not apply to a policy issued to an employer group.

1529 Section 25. Section 31A-22-610.5 is amended to read:

1530 **31A-22-610.5. Dependent coverage.**

1531 (1) As used in this section, "child" has the same meaning as defined in Section

1532 78B-12-102.

1533 (2) (a) Any individual or group accident and health insurance policy or health

1534 maintenance organization contract that provides coverage for a policyholder's or certificate

1535 holder's dependent may not terminate coverage of an unmarried dependent by reason of the

1536 dependent's age before the dependent's 26th birthday and shall, upon application, provide

1537 coverage for all unmarried dependents up to age 26.

1538 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be

1539 included in the premium on the same basis as other dependent coverage.

1540 (c) This section does not prohibit the employer from requiring the employee to pay all

1541 or part of the cost of coverage for unmarried dependents.

1542 (d) An individual health insurance policy, group health insurance policy, or health
1543 maintenance organization shall continue in force coverage for a dependent through the last day
1544 of the month in which the dependent ceases to be a dependent:

1545 (i) if premiums are paid; and

1546 (ii) notwithstanding Section [31A-8-402.3](#), [31A-8-402.5](#), [31A-22-721](#), [31A-30-107.1](#),
1547 or [31A-30-107.3](#).

1548 (3) An individual or group accident and health insurance policy or health maintenance
1549 organization contract shall reinstate dependent coverage, and for purposes of all exclusions and
1550 limitations, shall treat the dependent as if the coverage had been in force since it was
1551 terminated; if:

1552 (a) the dependent has not reached the age of 26 by July 1, 1995;

1553 (b) the dependent had coverage prior to July 1, 1994;

1554 (c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age
1555 of the dependent; and

1556 (d) the policy has not been terminated since the dependent's coverage was terminated.

1557 (4) (a) When a parent is required by a court or administrative order to provide health
1558 insurance coverage for a child, an accident and health insurer may not deny enrollment of a
1559 child under the accident and health insurance plan of the child's parent on the grounds the
1560 child:

1561 (i) was born out of wedlock and is entitled to coverage under Subsection (5);

1562 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child
1563 under the custodial parent's policy;

1564 (iii) is not claimed as a dependent on the parent's federal tax return; or

1565 (iv) does not reside with the parent or in the insurer's service area.

1566 (b) A child enrolled as required under Subsection (4)(a)(iv) is subject to the terms of
1567 the accident and health insurance plan contract pertaining to services received outside of an

1568 insurer's service area. A health maintenance organization shall comply with Section
1569 31A-8-502.

1570 (5) When a child has accident and health coverage through an insurer of a noncustodial
1571 parent, and when requested by the noncustodial or custodial parent, the insurer shall:

1572 (a) provide information to the custodial parent as necessary for the child to obtain
1573 benefits through that coverage, but the insurer or employer, or the agents or employees of either
1574 of them, are not civilly or criminally liable for providing information in compliance with this
1575 Subsection (5)(a), whether the information is provided pursuant to a verbal or written request;

1576 (b) permit the custodial parent or the service provider, with the custodial parent's
1577 approval, to submit claims for covered services without the approval of the noncustodial
1578 parent; and

1579 (c) make payments on claims submitted in accordance with Subsection (5)(b) directly
1580 to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid
1581 agency.

1582 (6) When a parent is required by a court or administrative order to provide health
1583 coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

1584 (a) permit the parent to enroll, under the family coverage, a child who is otherwise
1585 eligible for the coverage without regard to an enrollment season restrictions;

1586 (b) if the parent is enrolled but fails to make application to obtain coverage for the
1587 child, enroll the child under family coverage upon application of the child's other parent, the
1588 state agency administering the Medicaid program, or the state agency administering 42 U.S.C.
1589 Sec. 651 through 669, the child support enforcement program; and

1590 (c) (i) when the child is covered by an individual policy, not disenroll or eliminate
1591 coverage of the child unless the insurer is provided satisfactory written evidence that:

1592 (A) the court or administrative order is no longer in effect; or

1593 (B) the child is or will be enrolled in comparable accident and health coverage through
1594 another insurer which will take effect not later than the effective date of disenrollment; or

1595 (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of
1596 the child unless the employer is provided with satisfactory written evidence, which evidence is
1597 also provided to the insurer, that Subsection (9)(c)(i), (ii) or (iii) has happened.

1598 (7) An insurer may not impose requirements on a state agency that has been assigned
1599 the rights of an individual eligible for medical assistance under Medicaid and covered for
1600 accident and health benefits from the insurer that are different from requirements applicable to
1601 an agent or assignee of any other individual so covered.

1602 (8) Insurers may not reduce their coverage of pediatric vaccines below the benefit level
1603 in effect on May 1, 1993.

1604 (9) When a parent is required by a court or administrative order to provide health
1605 coverage, which is available through an employer doing business in this state, the employer
1606 shall:

1607 (a) permit the parent to enroll under family coverage any child who is otherwise
1608 eligible for coverage without regard to any enrollment season restrictions;

1609 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,
1610 enroll the child under family coverage upon application by the child's other parent, by the state
1611 agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec.
1612 651 through 669, the child support enforcement program;

1613 (c) not disenroll or eliminate coverage of the child unless the employer is provided
1614 satisfactory written evidence that:

1615 (i) the court order is no longer in effect;

1616 (ii) the child is or will be enrolled in comparable coverage which will take effect no
1617 later than the effective date of disenrollment; or

1618 (iii) the employer has eliminated family health coverage for all of its employees; and

1619 (d) withhold from the employee's compensation the employee's share, if any, of
1620 premiums for health coverage and to pay this amount to the insurer.

1621 (10) An order issued under Section [62A-11-326.1](#) may be considered a "qualified

1622 medical support order" for the purpose of enrolling a dependent child in a group accident and
1623 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income
1624 Security Act of 1974.

1625 (11) This section does not affect any insurer's ability to require as a precondition of any
1626 child being covered under any policy of insurance that:

1627 (a) the parent continues to be eligible for coverage;

1628 (b) the child shall be identified to the insurer with adequate information to comply with
1629 this section; and

1630 (c) the premium shall be paid when due.

1631 (12) ~~[The provisions of this section apply]~~ This section applies to employee welfare
1632 benefit plans as defined in Section 26-19-2.

1633 ~~[(13) The commissioner shall adopt rules interpreting and implementing this section
1634 with regard to out-of-area court ordered dependent coverage.]~~

1635 (13) (a) A policy that provides coverage to a child of a group member may not deny
1636 eligibility for coverage to a child solely because:

1637 (i) the child does not reside with the insured; or

1638 (ii) the child is solely dependent on a former spouse of the insured rather than on the
1639 insured.

1640 (b) A child who does not reside with the insured may be excluded on the same basis as
1641 a child who resides with the insured.

1642 Section 26. Section 31A-22-614.5 is amended to read:

1643 **31A-22-614.5. Uniform claims processing -- Electronic exchange of health
1644 information.**

1645 (1) (a) Except as provided in Subsection (1)(c), ~~[all insurers]~~ an insurer offering health
1646 insurance shall use a uniform claim form and uniform billing and claim codes.

1647 (b) Beginning January 1, 2011, all health benefit plans, and dental and vision plans,
1648 shall provide for the electronic exchange of uniform:

1649 (i) eligibility and coverage information; and
1650 (ii) coordination of benefits information.
1651 (c) For purposes of Subsection (1)(a), "health insurance" does not include a policy or
1652 certificate that provides benefits solely for:
1653 (i) income replacement; or
1654 (ii) long-term care.
1655 (2) (a) The uniform electronic standards and information required in Subsection (1)
1656 shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3,
1657 Utah Administrative Rulemaking Act.
1658 (b) When adopting rules under this section the commissioner:
1659 (i) shall:
1660 (A) consult with national and state organizations involved with the standardized
1661 exchange of health data, and the electronic exchange of health data, to develop the standards
1662 for the use and electronic exchange of uniform:
1663 (I) claim forms;
1664 (II) billing and claim codes;
1665 (III) insurance eligibility and coverage information; and
1666 (IV) coordination of benefits information; and
1667 (B) meet federal mandatory minimum standards following the adoption of national
1668 requirements for transaction and data elements in the federal Health Insurance Portability and
1669 Accountability Act;
1670 (ii) may not require an insurer or administrator to use a specific software product or
1671 vendor; and
1672 (iii) may require an insurer who participates in the all payer database created under
1673 Section [26-33a-106.1](#) to allow data regarding demographic and insurance coverage information
1674 to be electronically shared with the state's designated secure health information master person
1675 index to be used:

1676 (A) in compliance with data security standards established by:
1677 (I) the federal Health Insurance Portability and Accountability Act; and
1678 (II) the electronic commerce agreements established in a business associate agreement;
1679 and
1680 (B) for the purpose of coordination of health benefit plans.
1681 (3) (a) The commissioner shall coordinate the administrative rules adopted under the
1682 provisions of this section with the administrative rules adopted by the Department of Health for
1683 the implementation of the standards for the electronic exchange of clinical health information
1684 under Section 26-1-37. The department shall establish procedures for developing the rules
1685 adopted under this section, which ensure that the Department of Health is given the opportunity
1686 to comment on proposed rules.
1687 (b) (i) The commissioner may provide information to health care providers regarding
1688 resources available to a health care provider to verify whether a health care provider's practice
1689 management software system meets the uniform electronic standards for data exchange
1690 required by this section.
1691 (ii) The commissioner may provide the information described in Subsection (3)(b)(i)
1692 by partnering with:
1693 (A) a not-for-profit, broad based coalition of state health care insurers and health care
1694 providers who are involved in the electronic exchange of the data required by this section; or
1695 (B) some other person that the commissioner determines is appropriate to provide the
1696 information described in Subsection (3)(b)(i).
1697 (c) The commissioner shall regulate any fees charged by insurers to the providers for:
1698 (i) uniform claim forms;
1699 (ii) electronic billing; or
1700 (iii) the electronic exchange of clinical health information permitted by Section
1701 26-1-37.
1702 (4) This section does not require a person to provide information concerning an

1703 employer self-insured employee welfare benefit plan as defined in 29 U.S.C. Sec. 1002(1).

1704 Section 27. Section **31A-22-617** is amended to read:

1705 **31A-22-617. Preferred provider contract provisions.**

1706 Health insurance policies may provide for insureds to receive services or
1707 reimbursement under the policies in accordance with preferred health care provider contracts as
1708 follows:

1709 (1) Subject to restrictions under this section, an insurer or third party administrator may
1710 enter into contracts with health care providers as defined in Section **78B-3-403** under which the
1711 health care providers agree to supply services, at prices specified in the contracts, to persons
1712 insured by an insurer.

1713 (a) (i) A health care provider contract may require the health care provider to accept the
1714 specified payment in this Subsection (1) as payment in full, relinquishing the right to collect
1715 additional amounts from the insured person.

1716 (ii) In a dispute involving a provider's claim for reimbursement, the same shall be
1717 determined in accordance with applicable law, the provider contract, the subscriber contract,
1718 and the insurer's written payment policies in effect at the time services were rendered.

1719 (iii) If the parties are unable to resolve their dispute, the matter shall be subject to
1720 binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except
1721 the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii)
1722 does not apply to the claim of a general acute hospital to the extent it is inconsistent with the
1723 hospital's provider agreement.

1724 (iv) An organization may not penalize a provider solely for pursuing a claims dispute
1725 or otherwise demanding payment for a sum believed owing.

1726 (v) If an insurer permits another entity with which it does not share common ownership
1727 or control to use or otherwise lease one or more of the organization's networks of participating
1728 providers, the organization shall ensure, at a minimum, that the entity pays participating
1729 providers in accordance with the same fee schedule and general payment policies as the

1730 organization would for that network.

1731 (b) The insurance contract may reward the insured for selection of preferred health care
1732 providers by:

1733 (i) reducing premium rates;

1734 (ii) reducing deductibles;

1735 (iii) coinsurance;

1736 (iv) other copayments; or

1737 (v) any other reasonable manner.

1738 (c) If the insurer is a managed care organization, as defined in Subsection

1739 [31A-27a-403](#)(1)(f):

1740 (i) the insurance contract and the health care provider contract shall provide that in the
1741 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

1742 (A) require the health care provider to continue to provide health care services under
1743 the contract until the earlier of:

1744 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for
1745 liquidation; or

1746 (II) the date the term of the contract ends; and

1747 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to
1748 receive from the managed care organization during the time period described in Subsection
1749 (1)(c)(i)(A);

1750 (ii) the provider is required to:

1751 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

1752 (B) relinquish the right to collect additional amounts from the insolvent managed care
1753 organization's enrollee, as defined in Subsection [31A-27a-403](#)(1)(b);

1754 (iii) if the contract between the health care provider and the managed care organization
1755 has not been reduced to writing, or the contract fails to contain the requirements described in
1756 Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

1757 (A) sums owed by the insolvent managed care organization; or
1758 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
1759 (iv) the following may not bill or maintain an action at law against an enrollee to
1760 collect sums owed by the insolvent managed care organization or the amount of the regular fee
1761 reduction authorized under Subsection (1)(c)(i)(B):
1762 (A) a provider;
1763 (B) an agent;
1764 (C) a trustee; or
1765 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
1766 (v) notwithstanding Subsection (1)(c)(i):
1767 (A) a rehabilitator or liquidator may not reduce a fee ~~by~~ to less than 75% of the
1768 provider's regular fee set forth in the contract; and
1769 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments
1770 for services received from the provider that the enrollee was required to pay before the filing
1771 of:
1772 (I) a petition for rehabilitation; or
1773 (II) a petition for liquidation.
1774 (2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health
1775 care provider contracts is subject to the reimbursement requirements in Section [31A-8-501](#) on
1776 or after January 1, 2014.
1777 (b) When reimbursing for services of health care providers not under contract, the
1778 insurer may make direct payment to the insured.
1779 (c) An insurer using preferred health care provider contracts may impose a deductible
1780 on coverage of health care providers not under contract.
1781 (d) When selecting health care providers with whom to contract under Subsection (1),
1782 an insurer may not unfairly discriminate between classes of health care providers, but may
1783 discriminate within a class of health care providers, subject to Subsection (7).

1784 (e) For purposes of this section, unfair discrimination between classes of health care
1785 providers includes:

1786 (i) refusal to contract with class members in reasonable proportion to the number of
1787 insureds covered by the insurer and the expected demand for services from class members; and

1788 (ii) refusal to cover procedures for one class of providers that are:

1789 (A) commonly used by members of the class of health care providers for the treatment
1790 of illnesses, injuries, or conditions;

1791 (B) otherwise covered by the insurer; and

1792 (C) within the scope of practice of the class of health care providers.

1793 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
1794 to the insured that it has entered into preferred health care provider contracts. The insurer shall
1795 provide sufficient detail on the preferred health care provider contracts to permit the insured to
1796 agree to the terms of the insurance contract. The insurer shall provide at least the following
1797 information:

1798 (a) a list of the health care providers under contract, and if requested their business
1799 locations and specialties;

1800 (b) a description of the insured benefits, including deductibles, coinsurance, or other
1801 copayments;

1802 (c) a description of the quality assurance program required under Subsection (4); and

1803 (d) a description of the adverse benefit determination procedures required under
1804 Subsection (5).

1805 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
1806 assurance program for assuring that the care provided by the health care providers under
1807 contract meets prevailing standards in the state.

1808 (b) The commissioner in consultation with the executive director of the Department of
1809 Health may designate qualified persons to perform an audit of the quality assurance program.

1810 The auditors shall have full access to all records of the organization and its health care

1811 providers, including medical records of individual patients.

1812 (c) The information contained in the medical records of individual patients shall
1813 remain confidential. All information, interviews, reports, statements, memoranda, or other data
1814 furnished for purposes of the audit and any findings or conclusions of the auditors are
1815 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
1816 proceeding except hearings before the commissioner concerning alleged violations of this
1817 section.

1818 (5) An insurer using preferred health care provider contracts shall provide a reasonable
1819 procedure for resolving complaints and adverse benefit determinations initiated by the insureds
1820 and health care providers.

1821 (6) An insurer may not contract with a health care provider for treatment of illness or
1822 injury unless the health care provider is licensed to perform that treatment.

1823 (7) (a) A health care provider or insurer may not discriminate against a preferred health
1824 care provider for agreeing to a contract under Subsection (1).

1825 (b) A health care provider licensed to treat an illness or injury within the scope of the
1826 health care provider's practice, who is willing and able to meet the terms and conditions
1827 established by the insurer for designation as a preferred health care provider, shall be able to
1828 apply for and receive the designation as a preferred health care provider. Contract terms and
1829 conditions may include reasonable limitations on the number of designated preferred health
1830 care providers based upon substantial objective and economic grounds, or expected use of
1831 particular services based upon prior provider-patient profiles.

1832 (8) Upon the written request of a provider excluded from a provider contract, the
1833 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
1834 based on the criteria set forth in Subsection (7)(b).

1835 (9) Nothing in this section is to be construed as to require an insurer to offer a certain
1836 benefit or service as part of a health benefit plan.

1837 (10) This section does not apply to catastrophic mental health coverage provided in

1838 accordance with Section 31A-22-625.

1839 (11) Notwithstanding Subsection (1), Subsection (7)(b), and Section 31A-22-618, an
1840 insurer or third party administrator is not required to, but may, enter into a contract with a
1841 licensed athletic trainer, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

1842 Section 28. Section 31A-22-645 is enacted to read:

1843 **31A-22-645. Alcohol and drug dependency treatment.**

1844 (1) An insurer offering a health benefit plan providing coverage for alcohol or drug
1845 dependency treatment may require an inpatient facility to be licensed by:

1846 (a) (i) the Department of Human Services, under Title 62A, Chapter 2, Licensure of
1847 Programs and Facilities; or

1848 (ii) the Department of Health; or

1849 (b) for an inpatient facility located outside the state, a state agency similar to one
1850 described in Subsection (1)(a).

1851 (2) For inpatient coverage provided pursuant to Subsection (1), an insurer may require
1852 an inpatient facility to be accredited by the following:

1853 (a) the Joint Commission; and

1854 (b) one other nationally recognized accrediting agency.

1855 Section 29. Section 31A-22-701 is amended to read:

1856 **31A-22-701. Groups eligible for group or blanket insurance.**

1857 (1) As used in this section, "association group" means a lawfully formed association of
1858 individuals or business entities that:

1859 (a) purchases insurance on a group basis on behalf of members; and

1860 (b) is formed and maintained in good faith for purposes other than obtaining insurance.

1861 (2) A group accident and health insurance policy may be issued to:

1862 (a) a group:

1863 (i) to which a group life insurance policy may be issued under Sections 31A-22-502,
1864 31A-22-503, 31A-22-504, 31A-22-506, 31A-22-507, and 31A-22-509; and

1865 (ii) that is formed and maintained in good faith for a purpose other than obtaining
1866 insurance;

1867 (b) an association group that:

1868 (i) has been actively in existence for at least five years;

1869 (ii) has a constitution and bylaws;

1870 (iii) has a shared or common purpose that is not primarily a business or customer
1871 relationship;

1872 [~~(iii)~~] (iv) is formed and maintained in good faith for purposes other than obtaining
1873 insurance;

1874 [~~(iv)~~] (v) does not condition membership in the association group on any health
1875 status-related factor relating to an individual, including an employee of an employer or a
1876 dependent of an employee;

1877 [~~(v)~~] (vi) makes accident and health insurance coverage offered through the association
1878 group available to all members regardless of any health status-related factor relating to the
1879 members or individuals eligible for coverage through a member;

1880 [~~(vi)~~] (vii) does not make accident and health insurance coverage offered through the
1881 association group available other than in connection with a member of the association group;
1882 and

1883 [~~(vii)~~] (viii) is actuarially sound; or

1884 (c) a group specifically authorized by the commissioner under Section 31A-22-509,
1885 upon a finding that:

1886 (i) authorization is not contrary to the public interest;

1887 (ii) the group is actuarially sound;

1888 (iii) formation of the proposed group may result in economies of scale in acquisition,
1889 administrative, marketing, and brokerage costs;

1890 (iv) the insurance policy, insurance certificate, or other indicia of coverage that will be
1891 offered to the proposed group is substantially equivalent to insurance policies that are

1892 otherwise available to similar groups;

1893 (v) the group would not present hazards of adverse selection;

1894 (vi) the premiums for the insurance policy and any contributions by or on behalf of the

1895 insured persons are reasonable in relation to the benefits provided; and

1896 (vii) the group is formed and maintained in good faith for a purpose other than

1897 obtaining insurance.

1898 (3) A blanket accident and health insurance policy:

1899 (a) covers a defined class of persons;

1900 (b) may not be offered or underwritten on an individual basis;

1901 (c) shall cover only a group that is:

1902 (i) actuarially sound; and

1903 (ii) formed and maintained in good faith for a purpose other than obtaining insurance;

1904 and

1905 (d) may be issued only to:

1906 (i) a common carrier or an operator, owner, or lessee of a means of transportation, as

1907 policyholder, covering persons who may become passengers as defined by reference to the

1908 person's travel status;

1909 (ii) an employer, as policyholder, covering any group of employees, dependents, or

1910 guests, as defined by reference to specified hazards incident to any activities of the

1911 policyholder;

1912 (iii) an institution of learning, including a school district, a school jurisdictional unit, or

1913 the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering

1914 students, teachers, or employees;

1915 (iv) a religious, charitable, recreational, educational, or civic organization, or branch of

1916 one of those organizations, as policyholder, covering a group of members or participants as

1917 defined by reference to specified hazards incident to the activities sponsored or supervised by

1918 the policyholder;

1919 (v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering
1920 members, campers, employees, officials, or supervisors;

1921 (vi) a volunteer fire department, first aid, civil defense, or other similar volunteer
1922 organization, as policyholder, covering a group of members or participants as defined by
1923 reference to specified hazards incident to activities sponsored, supervised, or participated in by
1924 the policyholder;

1925 (vii) a newspaper or other publisher, as policyholder, covering its carriers;

1926 (viii) an association, including a labor union, that has a constitution and bylaws and
1927 that is organized in good faith for purposes other than that of obtaining insurance, as
1928 policyholder, covering a group of members or participants as defined by reference to specified
1929 hazards incident to the activities or operations sponsored or supervised by the policyholder; and

1930 (ix) any other class of risks that, in the judgment of the commissioner, may be properly
1931 eligible for blanket accident and health insurance.

1932 (4) The judgment of the commissioner may be exercised on the basis of:

1933 (a) individual risks;

1934 (b) a class of risks; or

1935 (c) both Subsections (4)(a) and (b).

1936 Section 30. Section **31A-22-716** is amended to read:

1937 **31A-22-716. Required provision for notice of termination.**

1938 (1) ~~Every~~ A policy for group or blanket accident and health coverage issued or
1939 renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30
1940 days prior written notice of termination to each employee or group member and to notify each
1941 employee or group member of the employee's or group member's rights to continue coverage
1942 upon termination.

1943 (2) An insurer's monthly notice to the policyholder of premium payments due shall
1944 include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers
1945 shall provide a sample notice to the policyholder at least once a year.

1946 ~~[(3) For the purpose of compliance with federal law and the Health Insurance~~
1947 ~~Portability and Accountability Act, all health benefit plans, health insurers, and student health~~
1948 ~~plans shall provide a certificate of creditable coverage to each covered person upon the person's~~
1949 ~~termination from the plan as soon as reasonably possible.]~~

1950 Section 31. Section **31A-22-721** is amended to read:

1951 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**
1952 **nonrenewal.**

1953 (1) Except as otherwise provided in this section, a health benefit plan for a plan
1954 sponsor is renewable and continues in force:

1955 (a) with respect to all eligible employees and dependents; and

1956 (b) at the option of the plan sponsor.

1957 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed for a
1958 network plan, if:

1959 (a) there is no longer any enrollee under the group health plan who lives, resides, or
1960 works in:

1961 (i) the service area of the insurer; or

1962 (ii) the area for which the insurer is authorized to do business; or

1963 (b) for coverage made available in the small or large employer market only through an
1964 association, if:

1965 (i) the employer's membership in the association ceases; and

1966 (ii) the coverage is terminated uniformly without regard to any health status-related
1967 factor relating to any covered individual.

1968 (3) A health benefit plan for a plan sponsor may be discontinued if:

1969 (a) a condition described in Subsection (2) exists;

1970 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
1971 terms of the contract;

1972 (c) the plan sponsor:

- 1973 (i) performs an act or practice that constitutes fraud; or
- 1974 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 1975 coverage;
- 1976 (d) the insurer:
- 1977 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or
- 1978 issued for delivery in this state;
- 1979 (ii) (A) provides notice of the discontinuation in writing:
- 1980 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
- 1981 (II) at least 90 days before the date the coverage will be discontinued;
- 1982 (B) provides notice of the discontinuation in writing:
- 1983 (I) to the commissioner; and
- 1984 (II) at least three working days prior to the date the notice is sent to the affected plan
- 1985 sponsors, employees, and dependents of plan sponsors or employees;
- 1986 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
- 1987 other health benefit [~~products~~] plans currently being offered:
- 1988 (I) by the insurer in the market; or
- 1989 (II) in the case of a large employer, any other health benefit plan currently being
- 1990 offered in that market; and
- 1991 (D) in exercising the option to discontinue that [~~product~~] health benefit plan and in
- 1992 offering the option of coverage in this section, the insurer acts uniformly without regard to:
- 1993 (I) the claims experience of a plan sponsor;
- 1994 (II) any health status-related factor relating to any covered participant or beneficiary; or
- 1995 (III) any health status-related factor relating to a new participant or beneficiary who
- 1996 may become eligible for coverage; or
- 1997 (e) the insurer:
- 1998 (i) elects to discontinue all of the insurer's health benefit plans:
- 1999 (A) in the small employer market; or

- 2000 (B) the large employer market; or
- 2001 (C) both the small and large employer markets; and
- 2002 (ii) (A) provides notice of the discontinuance in writing:
- 2003 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
- 2004 (II) at least 180 days before the date the coverage will be discontinued;
- 2005 (B) provides notice of the discontinuation in writing:
- 2006 (I) to the commissioner in each state in which an affected insured individual is known
- 2007 to reside; and
- 2008 (II) at least 30 business days prior to the date the notice is sent to the affected plan
- 2009 sponsors, employees, and dependents of a plan sponsor or employee;
- 2010 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
- 2011 market; and
- 2012 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
- 2013 (4) A large employer health benefit plan may be discontinued or nonrenewed:
- 2014 (a) if a condition described in Subsection (2) exists; or
- 2015 (b) for noncompliance with the insurer's:
- 2016 (i) minimum participation requirements; or
- 2017 (ii) employer contribution requirements.
- 2018 (5) A small employer health benefit plan may be discontinued or nonrenewed:
- 2019 (a) if a condition described in Subsection (2) exists; or
- 2020 (b) for noncompliance with the insurer's employer contribution requirements.
- 2021 (6) A small employer health benefit plan may be nonrenewed:
- 2022 (a) if a condition described in Subsection (2) exists; or
- 2023 (b) for noncompliance with the insurer's minimum participation requirements.
- 2024 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
- 2025 discontinued if after issuance of coverage the eligible employee:
- 2026 (i) engages in an act or practice that constitutes fraud in connection with the coverage;

2027 or

2028 (ii) makes an intentional misrepresentation of material fact in connection with the
2029 coverage.

2030 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:

2031 (i) 12 months after the date of discontinuance; and

2032 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
2033 to reenroll.

2034 (c) At the time the eligible employee's coverage is discontinued under Subsection
2035 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
2036 discontinued.

2037 (d) An eligible employee may not be discontinued under this Subsection (7) because of
2038 a fraud or misrepresentation that relates to health status.

2039 (8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue
2040 offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new
2041 business in such market in this state for a period of five years beginning on the date of
2042 discontinuation of the last coverage that is discontinued.

2043 (b) The commissioner may waive the prohibition under Subsection (8)(a) when the
2044 commissioner finds that waiver is in the public interest:

2045 (i) to promote competition; or

2046 (ii) to resolve inequity in the marketplace.

2047 (9) If an insurer is doing business in one established geographic service area of the
2048 state, this section applies only to the insurer's operations in that geographic service area.

2049 (10) An insurer may modify a health benefit plan for a plan sponsor only:

2050 (a) at the time of coverage renewal; and

2051 (b) if the modification is effective uniformly among all plans with a particular product
2052 or service.

2053 (11) For purposes of this section, a reference to "plan sponsor" includes a reference to

2054 the employer:

2055 (a) with respect to coverage provided to an employer member of the association; and

2056 (b) if the health benefit plan is made available by an insurer in the employer market

2057 only through:

2058 (i) an association;

2059 (ii) a trust; or

2060 (iii) a discretionary group.

2061 (12) (a) A small employer that, after purchasing a health benefit plan in the small group
2062 market, employs on average more than 50 eligible employees on each business day in a
2063 calendar year may continue to renew the health benefit plan purchased in the small group
2064 market.

2065 (b) A large employer that, after purchasing a health benefit plan in the large group
2066 market, employs on average less than 51 eligible employees on each business day in a calendar
2067 year may continue to renew the health benefit plan purchased in the large group market.

2068 (13) An insurer offering employer sponsored health benefit plans shall comply with the
2069 Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.

2070 Section 32. Section **31A-22-801** is amended to read:

2071 **31A-22-801. Scope of part.**

2072 (1) Except as provided under Subsection (2), all life insurance and accident and health
2073 insurance in connection with loans or other credit transactions are subject to this part.

2074 (2) (a) Insurance written in connection with a [~~loan or other~~] credit transaction [~~of more~~
2075 ~~than 10 years duration~~] is not subject to this part, but is subject to other provisions of this
2076 title[-], if the credit transaction is:

2077 (i) secured by a first mortgage or deed of trust; and

2078 (ii) made to finance the purchase of real property or the construction of a dwelling
2079 thereon, or to refinance a prior credit transaction made for such a purpose.

2080 (b) Isolated transactions on the part of an insurer that are not related to an agreement or

2081 plan for insuring debtors of the creditor are not subject to this part.

2082 Section 33. Section **31A-22-1902** is amended to read:

2083 **31A-22-1902. Definitions.**

2084 As used in this part:

2085 (1) "Administrator" means the same as that term is defined in Section [67-4a-102](#).

2086 (2) "Asymmetric conduct" means an insurer's use of the death master file or other
2087 similar database before July 1, 2015, in connection with searching for information regarding
2088 whether annuitants under the insurer's annuities might be deceased, but not in connection with
2089 whether the insureds under the insurer's policies might be deceased.

2090 (3) (a) "Contract" means an annuity contract.

2091 (b) "Contract" does not include an annuity used to fund an employment-based
2092 retirement plan or program when:

2093 (i) the insurer does not perform the record keeping services; or

2094 (ii) the insurer is not committed by terms of the annuity contract to pay death benefits
2095 to the beneficiaries of specific plan participants.

2096 (4) "Death master file" means the United States Social Security Administration's Death
2097 Master File or another database or service that is at least as comprehensive as the United States
2098 Social Security Administration's Death Master File for determining that a person has reportedly
2099 died.

2100 (5) "Death master file match" means a search of a death master file that results in a
2101 match of the Social Security number, or the name and date of birth of an insured, annuity
2102 owner, or retained asset account holder.

2103 [~~(6) "Knowledge of death" means:~~]

2104 [~~(a) receipt of an original or valid copy of a certified death certificate; or]~~

2105 [~~(b) a death master file match validated by the insurer in accordance with Subsection~~

2106 [31A-22-1903\(1\)\(a\)](#).]

2107 [~~(7)~~] (6) (a) "Policy" means a policy or certificate of life insurance that provides a death

2108 benefit.

2109 (b) "Policy" does not include:

2110 (i) a policy or certificate of life insurance that provides a death benefit under an
2111 employee benefit plan:

2112 (A) subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec.
2113 1002, as periodically amended; or

2114 (B) under ~~[any]~~ a federal employee benefit program;

2115 (ii) a policy or certificate of life insurance that is used to fund a preneed funeral
2116 contract or prearrangement;

2117 (iii) a policy or certificate of credit life or accidental death insurance; or

2118 (iv) a policy issued to a group master policyholder for which the insurer does not
2119 provide record keeping services.

2120 ~~[(8)]~~ (7) "Record keeping services" means those circumstances under which the insurer
2121 agrees with a group policy or contract customer to be responsible for obtaining, maintaining,
2122 and administering, in its own or its agents' systems, information about each individual insured
2123 under an insured's group insurance contract, or a line of coverage under the group insurance
2124 contract, at least the following information:

2125 (a) social security number, or name and date of birth;

2126 (b) beneficiary designation information;

2127 (c) coverage eligibility;

2128 (d) benefit amount; and

2129 (e) premium payment status.

2130 ~~[(9)]~~ (8) "Retained asset account" means ~~[any]~~ a mechanism whereby the settlement of
2131 proceeds payable under a policy or contract is accomplished by the insurer or an entity acting
2132 on behalf of the insurer by depositing the proceeds into an account with check or draft writing
2133 privileges, where those proceeds are retained by the insurer or its agent, pursuant to a
2134 supplementary contract not involving annuity benefits other than death benefits.

2135 Section 34. Section **31A-23a-111** is amended to read:

2136 **31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
2137 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**

2138 (1) A license type issued under this chapter remains in force until:

2139 (a) revoked or suspended under Subsection (5);

2140 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
2141 administrative action;

2142 (c) the licensee dies or is adjudicated incompetent as defined under:

2143 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

2144 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
2145 Minors;

2146 (d) lapsed under Section [31A-23a-113](#); or

2147 (e) voluntarily surrendered.

2148 (2) The following may be reinstated within one year after the day on which the license
2149 is no longer in force:

2150 (a) a lapsed license; or

2151 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
2152 not be reinstated after the license period in which the license is voluntarily surrendered.

2153 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
2154 license, submission and acceptance of a voluntary surrender of a license does not prevent the
2155 department from pursuing additional disciplinary or other action authorized under:

2156 (a) this title; or

2157 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
2158 Administrative Rulemaking Act.

2159 (4) A line of authority issued under this chapter remains in force until:

2160 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;

2161 or

- 2162 (b) the supporting license type:
- 2163 (i) is revoked or suspended under Subsection (5);
- 2164 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
- 2165 administrative action;
- 2166 (iii) lapses under Section [31A-23a-113](#); or
- 2167 (iv) is voluntarily surrendered; or
- 2168 (c) the licensee dies or is adjudicated incompetent as defined under:
- 2169 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
- 2170 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
- 2171 Minors.
- 2172 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an
- 2173 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
- 2174 commissioner may:
- 2175 (i) revoke:
- 2176 (A) a license; or
- 2177 (B) a line of authority;
- 2178 (ii) suspend for a specified period of 12 months or less:
- 2179 (A) a license; or
- 2180 (B) a line of authority;
- 2181 (iii) limit in whole or in part:
- 2182 (A) a license; or
- 2183 (B) a line of authority; [~~or~~]
- 2184 (iv) deny a license application[.];
- 2185 (v) assess a forfeiture under Subsection [31A-2-308\(1\)\(b\)\(i\)](#) or (1)(c)(i); or
- 2186 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and
- 2187 Subsection (5)(a)(v).
- 2188 (b) The commissioner may take an action described in Subsection (5)(a) if the

2189 commissioner finds that the licensee:

2190 (i) is unqualified for a license or line of authority under Section 31A-23a-104,

2191 31A-23a-105, or 31A-23a-107;

2192 (ii) violates:

2193 (A) an insurance statute;

2194 (B) a rule that is valid under Subsection 31A-2-201(3); or

2195 (C) an order that is valid under Subsection 31A-2-201(4);

2196 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other

2197 delinquency proceedings in any state;

2198 (iv) fails to pay a final judgment rendered against the person in this state within 60

2199 days after the day on which the judgment became final;

2200 (v) fails to meet the same good faith obligations in claims settlement that is required of

2201 admitted insurers;

2202 (vi) is affiliated with and under the same general management or interlocking

2203 directorate or ownership as another insurance producer that transacts business in this state

2204 without a license;

2205 (vii) refuses:

2206 (A) to be examined; or

2207 (B) to produce its accounts, records, and files for examination;

2208 (viii) has an officer who refuses to:

2209 (A) give information with respect to the insurance producer's affairs; or

2210 (B) perform any other legal obligation as to an examination;

2211 (ix) provides information in the license application that is:

2212 (A) incorrect;

2213 (B) misleading;

2214 (C) incomplete; or

2215 (D) materially untrue;

- 2216 (x) violates an insurance law, valid rule, or valid order of another regulatory agency in
- 2217 any jurisdiction;
- 2218 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
- 2219 (xii) improperly withholds, misappropriates, or converts money or properties received
- 2220 in the course of doing insurance business;
- 2221 (xiii) intentionally misrepresents the terms of an actual or proposed:
- 2222 (A) insurance contract;
- 2223 (B) application for insurance; or
- 2224 (C) life settlement;
- 2225 (xiv) is convicted of a felony;
- 2226 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
- 2227 (xvi) in the conduct of business in this state or elsewhere:
- 2228 (A) uses fraudulent, coercive, or dishonest practices; or
- 2229 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
- 2230 (xvii) has an insurance license, or its equivalent, denied, suspended, or revoked in
- 2231 another state, province, district, or territory;
- 2232 (xviii) forges another's name to:
- 2233 (A) an application for insurance; or
- 2234 (B) a document related to an insurance transaction;
- 2235 (xix) improperly uses notes or another reference material to complete an examination
- 2236 for an insurance license;
- 2237 (xx) knowingly accepts insurance business from an individual who is not licensed;
- 2238 (xxi) fails to comply with an administrative or court order imposing a child support
- 2239 obligation;
- 2240 (xxii) fails to:
- 2241 (A) pay state income tax; or
- 2242 (B) comply with an administrative or court order directing payment of state income

2243 tax;

2244 (xxiii) violates or permits others to violate the federal Violent Crime Control and Law
2245 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
2246 prohibited from engaging in the business of insurance; or

2247 (xxiv) engages in a method or practice in the conduct of business that endangers the
2248 legitimate interests of customers and the public.

2249 (c) For purposes of this section, if a license is held by an agency, both the agency itself
2250 and any individual designated under the license are considered to be the holders of the license.

2251 (d) If an individual designated under the agency license commits an act or fails to
2252 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
2253 the commissioner may suspend, revoke, or limit the license of:

2254 (i) the individual;

2255 (ii) the agency, if the agency:

2256 (A) is reckless or negligent in its supervision of the individual; or

2257 (B) knowingly participates in the act or failure to act that is the ground for suspending,
2258 revoking, or limiting the license; or

2259 (iii) (A) the individual; and

2260 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

2261 (6) A licensee under this chapter is subject to the penalties for acting as a licensee
2262 without a license if:

2263 (a) the licensee's license is:

2264 (i) revoked;

2265 (ii) suspended;

2266 (iii) limited;

2267 (iv) surrendered in lieu of administrative action;

2268 (v) lapsed; or

2269 (vi) voluntarily surrendered; and

2270 (b) the licensee:
2271 (i) continues to act as a licensee; or
2272 (ii) violates the terms of the license limitation.
2273 (7) A licensee under this chapter shall immediately report to the commissioner:
2274 (a) a revocation, suspension, or limitation of the person's license in another state, the
2275 District of Columbia, or a territory of the United States;
2276 (b) the imposition of a disciplinary sanction imposed on that person by another state,
2277 the District of Columbia, or a territory of the United States; or
2278 (c) a judgment or injunction entered against that person on the basis of conduct
2279 involving:
2280 (i) fraud;
2281 (ii) deceit;
2282 (iii) misrepresentation; or
2283 (iv) a violation of an insurance law or rule.
2284 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
2285 license in lieu of administrative action may specify a time, not to exceed five years, within
2286 which the former licensee may not apply for a new license.
2287 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the
2288 former licensee may not apply for a new license for five years from the day on which the order
2289 or agreement is made without the express approval by the commissioner.
2290 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
2291 a license issued under this part if so ordered by a court.
2292 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
2293 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2294 Section 35. Section **31A-23a-115** is amended to read:
2295 **31A-23a-115. Appointment of individual and agency insurance producer, limited**
2296 **line producer, or managing general agent -- Reports and lists.**

2297 (1) (a) An insurer shall appoint an individual or agency with whom it has a contract as
2298 an insurance producer, limited line producer, or managing general agent to act on the insurer's
2299 behalf in order for the licensee to do business for the insurer in this state.

2300 (b) An insurer shall report to the commissioner, at intervals and in the form the
2301 commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah
2302 Administrative Rulemaking Act:

- 2303 (i) a new appointment; and
- 2304 (ii) a termination of appointment.

2305 (2) An insurer shall notify a producer that the producer's appointment is terminated by
2306 the insurer and of the reason for termination at an interval and in the form the commissioner
2307 establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
2308 Rulemaking Act.

2309 [~~(2)~~] (3) (a) (i) An insurer shall report to the commissioner the cause of termination of
2310 an appointment if:

2311 (A) the reason for termination is a reason described in Subsection 31A-23a-111(5)(b);
2312 or

2313 (B) the insurer has knowledge that the individual or agency licensee is found to have
2314 engaged in an activity described in Subsection 31A-23a-111(5)(b) by:

- 2315 (I) a court;
- 2316 (II) a government body; or
- 2317 (III) a self-regulatory organization, which the commissioner may define by rule made
2318 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2319 (ii) The information provided to the commissioner under this Subsection [~~(2)~~] (3) is a
2320 private record under Title 63G, Chapter 2, Government Records Access and Management Act.

2321 (b) An insurer is immune from civil action, civil penalty, or damages if the insurer
2322 complies in good faith with this Subsection [~~(2)~~] (3) in reporting to the commissioner the cause
2323 of termination of an appointment.

2324 (c) Notwithstanding any other provision in this section, an insurer is not immune from
2325 any action or resulting penalty imposed on the reporting insurer as a result of proceedings
2326 brought by or on behalf of the department if the action is based on evidence other than the
2327 report submitted in compliance with this Subsection [~~(2)~~] (3).

2328 [~~(3)~~] (4) If an insurer appoints an agency, the insurer need not appoint, report, or pay
2329 appointment reporting fees for an individual designated on the agency's license under Section
2330 31A-23a-302.

2331 [~~(4)~~] (5) If an insurer has a contract with or lists a licensee in a report submitted under
2332 Subsection [~~(2)~~] (3), there is a rebuttable presumption that in placing a risk with the insurer the
2333 contracted or appointed licensee or any of the licensee's licensed employees act on behalf of the
2334 insurer.

2335 Section 36. Section 31A-23a-203 is amended to read:

2336 **31A-23a-203. Training period requirements.**

2337 (1) A producer is eligible to become a surplus lines producer only if the producer:

2338 (a) has passed the applicable surplus lines producer examination;

2339 (b) has been a producer with property or casualty or both lines of authority for at least
2340 three years during the four years immediately preceding the date of application; and

2341 (c) has paid the applicable fee under Section 31A-3-103.

2342 (2) A person is eligible to become a consultant only if the person has acted in a
2343 capacity that would provide the person with preparation to act as an insurance consultant for a
2344 period aggregating not less than three years during the four years immediately preceding the
2345 date of application.

2346 (3) (a) A resident producer with an accident and health line of authority may only sell
2347 long-term care insurance if the producer:

2348 (i) initially completes a minimum of three hours of long-term care training before
2349 selling long-term care coverage; and

2350 (ii) after completing the training required by Subsection (3)(a)(i), completes a

2351 minimum of three hours of long-term care training during each subsequent two-year licensing
2352 period.

2353 (b) A course taken to satisfy a long-term care training requirement may be used toward
2354 satisfying a producer continuing education requirement.

2355 (c) Long-term care training is not a continuing education requirement to renew a
2356 producer license.

2357 (d) An insurer that issues long-term care insurance shall demonstrate to the
2358 commissioner, upon request, that a producer who is appointed by the insurer and who sells
2359 long-term care insurance coverage is in compliance with this Subsection (3).

2360 (4) (a) A resident producer with a property line of authority may only sell flood
2361 insurance coverage under the National Flood Insurance Program if the producer completes a
2362 minimum of three hours of flood insurance training related to the National Flood Insurance
2363 Program before selling flood insurance coverage.

2364 (b) A course taken to satisfy a flood insurance training requirement may be used
2365 toward satisfying a producer continuing education requirement.

2366 (c) Flood insurance training is not a continuing education requirement to renew a
2367 producer license.

2368 (d) An insurer that issues flood insurance shall demonstrate to the commissioner, upon
2369 request, that a producer who is appointed by the insurer and who sells flood insurance coverage
2370 is in compliance with this Subsection (4).

2371 [~~4~~] (5) The training periods required under this section apply only to an individual
2372 applying for a license under this chapter.

2373 Section 37. Section **31A-23a-302** is amended to read:

2374 **31A-23a-302. Agency designations.**

2375 (1) An agency shall designate an individual that has an individual producer, surplus
2376 lines producer, limited line producer, consultant, managing general agent, or reinsurance
2377 intermediary license to act on the agency's behalf in order for the licensee to do business for the

2378 agency in this state.

2379 (2) An agency shall report to the commissioner, at intervals and in the form the
2380 commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah
2381 Administrative Rulemaking Act:

- 2382 (a) a new designation; and
- 2383 (b) a terminated designation.

2384 (3) An agency shall notify an individual designee that the individual's designation is
2385 terminated by the agency and of the reason for termination at an interval and in the form the
2386 commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah
2387 Administrative Rulemaking Act.

2388 [~~(3)~~] (4) (a) An agency licensed under this chapter shall report to the commissioner the
2389 cause of termination of a designation if:

2390 (i) the reason for termination is a reason described in Subsection 31A-23a-111(5)(b);
2391 or

2392 (ii) the agency has knowledge that the individual licensee is found to have engaged in
2393 an activity described in Subsection 31A-23a-111(5)(b) by:

- 2394 (A) a court;
- 2395 (B) a government body; or
- 2396 (C) a self-regulatory organization, which the commissioner may define by rule made in
2397 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2398 (b) The information provided the commissioner under Subsection [~~(3)~~] (4)(a) is a
2399 private record under Title 63G, Chapter 2, Government Records Access and Management Act.

2400 (c) An agency is immune from civil action, civil penalty, or damages if the agency
2401 complies in good faith with this Subsection [~~(3)~~] (4) in reporting to the commissioner the cause
2402 of termination of a designation.

2403 (d) Notwithstanding any other provision in this section, an agency is not immune from
2404 an action or resulting penalty imposed on the reporting agency as a result of proceedings

2405 brought by or on behalf of the department if the action is based on evidence other than the
2406 report submitted in compliance with this Subsection [~~(3)~~] (4).

2407 [~~(4)~~] (5) An agency licensed under this chapter may act in a capacity for which it is
2408 licensed only through an individual who is licensed under this chapter to act in the same
2409 capacity.

2410 [~~(5)~~] (6) An agency licensed under this chapter shall designate and report to the
2411 commissioner in accordance with any rule made by the commissioner in accordance with Title
2412 63G, Chapter 3, Utah Administrative Rulemaking Act, the name of the designated responsible
2413 licensed individual who has authority to act on behalf of the agency in the matters pertaining to
2414 compliance with this title and orders of the commissioner.

2415 [~~(6)~~] (7) If an agency has a contract with or designates a licensee in reports submitted
2416 under Subsection (2) or [~~(5)~~] (6), there is a rebuttable presumption that the contracted or
2417 designated licensee acts on behalf of the agency.

2418 [~~(7)~~] (8) (a) When a license is held by an agency, both the agency itself and any
2419 individual contracted or designated under the agency license shall be considered to be the
2420 holder of the agency license for purposes of this section.

2421 (b) If an individual contracted or designated under the agency license commits an act or
2422 fails to perform a duty that is a ground for suspending, revoking, or limiting the agency license,
2423 or assessing a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i), the commissioner
2424 may assess a forfeiture, suspend, revoke, or limit the license of, or take a combination of these
2425 actions against:

2426 (i) the individual;

2427 (ii) the agency, if the agency:

2428 (A) is reckless or negligent in its supervision of the individual; or

2429 (B) knowingly participates in the act or failure to act that is the ground for assessing a
2430 forfeiture, or suspending, revoking, or limiting the license; or

2431 (iii) (A) the individual; and

2432 (B) the agency if the agency meets the requirements of Subsection [~~(7)~~] (8)(b)(ii).

2433 Section 38. Section **31A-23a-407** is amended to read:

2434 **31A-23a-407. Liability for acts of title insurance producers.**

2435 (1) Subject to the other provisions in this section, a title insurer that has a contract with
2436 or appoints an individual title insurance producer or an agency title insurance producer is liable
2437 to a buyer, seller, borrower, lender, or third party that deposits money with the individual title
2438 insurance producer or agency title insurance producer for the receipt and disbursement of
2439 money deposited with the individual title insurance producer or agency title insurance producer
2440 for a transaction when a commitment for a policy of title insurance of that title insurer is
2441 ordered, issued, or distributed or a title insurance policy of that title insurer is issued, except
2442 that once a title insurer is named in an issued commitment only that title insurer is liable as a
2443 title insurer under this section.

2444 (2) The liability of a title insurer under Subsection (1) and the liability of an individual
2445 title insurance producer or agency title insurance producer for the receipt and disbursement of
2446 money deposited with the individual title insurance producer or agency title insurance producer
2447 is limited to the amount of money received and disbursed, not to exceed the amount of
2448 proposed insurance set forth in the commitment or title insurance policy described in
2449 Subsection (1) plus 10% of the amount of the proposed insurance.

2450 (3) The liability described in Subsection (1) does not modify, mitigate, impair, or affect
2451 the contractual obligations between an individual title insurance producer or agency title
2452 insurance producer and the title insurer.

2453 (4) The liability of a title insurer with respect to the condition of title to the real
2454 property that is the subject of a title insurance policy or a title insurance commitment for a title
2455 insurance policy is limited to the terms, conditions, and stipulations contained in the title
2456 insurance policy or title commitment.

2457 Section 39. Section **31A-23a-412** is amended to read:

2458 **31A-23a-412. Place of business and residence address -- Records.**

2459 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:
2460 (i) the address and the one or more telephone numbers of the licensee's principal place
2461 of business; and

2462 (ii) a valid business email address at which the commissioner may contact the licensee.

2463 (b) If a licensee is an individual, in addition to complying with Subsection (1)(a) the
2464 individual shall register and maintain with the commissioner the individual's residence address
2465 and telephone number.

2466 (c) A licensee shall notify the commissioner within 30 days of a change of any of the
2467 following required to be registered with the commissioner under this section:

2468 (i) an address;

2469 (ii) a telephone number; or

2470 (iii) a business email address.

2471 (2) (a) Except as provided under Subsection (3), a licensee under this chapter or an
2472 insurer under Chapter 14, Foreign Insurers, shall keep at the principal place of business address
2473 registered under Subsection (1), separate and distinct books and records of the transactions
2474 consummated under the Utah license.

2475 (b) The books and records described in Subsection (2)(a) shall:

2476 (i) be in an organized form;

2477 (ii) be available to the commissioner for inspection upon reasonable notice; and

2478 (iii) include all of the following:

2479 (A) if the licensee is a producer, surplus lines producer, limited line producer,
2480 consultant, managing general agent, or reinsurance intermediary:

2481 (I) a record of each insurance contract procured by or issued through the licensee, with
2482 the names of insurers and insureds, the amount of premium and commissions or other
2483 compensation, and the subject of the insurance;

2484 (II) the names of any other producers, surplus lines producers, limited line producers,
2485 consultants, managing general agents, or reinsurance intermediaries from whom business is

2486 accepted, and of persons to whom commissions or allowances of any kind are promised or
2487 paid; and

2488 (III) a record of the consumer complaints forwarded to the licensee by an insurance
2489 regulator;

2490 (B) if the licensee is a consultant, a record of each agreement outlining the work
2491 performed and the fee for the work; and

2492 (C) any additional information which:

2493 (I) is customary for a similar business; or

2494 (II) may reasonably be required by the commissioner by rule made in accordance with
2495 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2496 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can
2497 be obtained immediately from a central storage place or elsewhere by on-line computer
2498 terminals located at the registered address.

2499 (4) A licensee who represents only a single insurer satisfies Subsection (2) if the
2500 insurer maintains the books and records pursuant to Subsection (2) at a place satisfying
2501 Subsections (1) and (5).

2502 (5) (a) The books and records maintained under Subsection (2) or Section
2503 [31A-23a-413](#) shall be available for the inspection of the commissioner during the business
2504 hours for a period of time after the date of the transaction as specified by the commissioner by
2505 rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, but
2506 in no case for less than three calendar years in addition to the current calendar year [~~plus three~~
2507 ~~years~~].

2508 (b) Discarding [~~books and records~~] a book or record after the applicable record
2509 retention period has expired does not place the licensee in violation of a later-adopted longer
2510 record retention period.

2511 Section 40. Section **31A-23a-501** is amended to read:

2512 **31A-23a-501. Licensee compensation.**

- 2513 (1) As used in this section:
- 2514 (a) "Commission compensation" includes funds paid to or credited for the benefit of a
2515 licensee from:
- 2516 (i) commission amounts deducted from insurance premiums on insurance sold by or
2517 placed through the licensee;
- 2518 (ii) commission amounts received from an insurer or another licensee as a result of the
2519 sale or placement of insurance; or
- 2520 (iii) overrides, bonuses, contingent bonuses, or contingent commissions received from
2521 an insurer or another licensee as a result of the sale or placement of insurance.
- 2522 (b) (i) "Compensation from an insurer or third party administrator" means
2523 commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,
2524 gifts, prizes, or any other form of valuable consideration:
- 2525 (A) whether or not payable pursuant to a written agreement; and
- 2526 (B) received from:
- 2527 (I) an insurer; or
- 2528 (II) a third party to the transaction for the sale or placement of insurance.
- 2529 (ii) "Compensation from an insurer or third party administrator" does not mean
2530 compensation from a customer that is:
- 2531 (A) a fee or pass-through costs as provided in Subsection (1)(e); or
- 2532 (B) a fee or amount collected by or paid to the producer that does not exceed an
2533 amount established by the commissioner by administrative rule.
- 2534 (c) (i) "Customer" means:
- 2535 (A) the person signing the application or submission for insurance; or
- 2536 (B) the authorized representative of the insured actually negotiating the placement of
2537 insurance with the producer.
- 2538 (ii) "Customer" does not mean a person who is a participant or beneficiary of:
- 2539 (A) an employee benefit plan; or

2540 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or
2541 negotiated by the producer or affiliate.

2542 (d) (i) "Noncommission compensation" includes all funds paid to or credited for the
2543 benefit of a licensee other than commission compensation.

2544 (ii) "Noncommission compensation" does not include charges for pass-through costs
2545 incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

2546 (e) "Pass-through costs" include:

2547 (i) costs for copying documents to be submitted to the insurer; and

2548 (ii) bank costs for processing cash or credit card payments.

2549 (2) A licensee may receive from an insured or from a person purchasing an insurance
2550 policy, noncommission compensation if the noncommission compensation is stated on a
2551 separate, written disclosure.

2552 (a) The disclosure required by this Subsection (2) shall:

2553 (i) include the signature of the insured or prospective insured acknowledging the
2554 noncommission compensation;

2555 (ii) clearly specify:

2556 (A) the amount of any known noncommission compensation; and

2557 (B) the type and amount, if known, of any potential and contingent noncommission
2558 compensation; and

2559 (iii) be provided to the insured or prospective insured before the performance of the
2560 service.

2561 (b) Noncommission compensation shall be:

2562 (i) limited to actual or reasonable expenses incurred for services; and

2563 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of
2564 business or for a specific service or services.

2565 (c) A copy of the signed disclosure required by this Subsection (2) shall be maintained
2566 by any licensee who collects or receives the noncommission compensation or any portion of

2567 the noncommission compensation.

2568 (d) All accounting records relating to noncommission compensation shall be
2569 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

2570 (3) (a) A licensee may receive noncommission compensation when acting as a
2571 producer for the insured in connection with the actual sale or placement of insurance if:

2572 (i) the producer and the insured have agreed on the producer's noncommission
2573 compensation; and

2574 (ii) the producer has disclosed to the insured the existence and source of any other
2575 compensation that accrues to the producer as a result of the transaction.

2576 (b) The disclosure required by this Subsection (3) shall:

2577 (i) include the signature of the insured or prospective insured acknowledging the
2578 noncommission compensation;

2579 (ii) clearly specify:

2580 (A) the amount of any known noncommission compensation;

2581 (B) the type and amount, if known, of any potential and contingent noncommission
2582 compensation; and

2583 (C) the existence and source of any other compensation; and

2584 (iii) be provided to the insured or prospective insured before the performance of the
2585 service.

2586 (c) The following additional noncommission compensation is authorized:

2587 (i) compensation received by a producer of a compensated corporate surety who under
2588 procedures approved by a rule or order of the commissioner is paid by surety bond principal
2589 debtors for extra services;

2590 (ii) compensation received by an insurance producer who is also licensed as a public
2591 adjuster under Section [31A-26-203](#), for services performed for an insured in connection with a
2592 claim adjustment, so long as the producer does not receive or is not promised compensation for
2593 aiding in the claim adjustment prior to the occurrence of the claim;

2594 (iii) compensation received by a consultant as a consulting fee, provided the consultant
2595 complies with the requirements of Section 31A-23a-401; or

2596 (iv) other compensation arrangements approved by the commissioner after a finding
2597 that they do not violate Section 31A-23a-401 and are not harmful to the public.

2598 (d) Subject to Section 31A-23a-402.5, a producer for the insured may receive
2599 compensation from an insured through an insurer, for the negotiation and sale of a health
2600 benefit plan, if there is a separate written agreement between the insured and the licensee for
2601 the compensation. An insurer who passes through the compensation from the insured to the
2602 licensee under this Subsection (3)(d) is not providing direct or indirect compensation or
2603 commission compensation to the licensee.

2604 (4) (a) For purposes of this Subsection (4):

2605 (i) "Large customer" means an employer who, with respect to a calendar year and to a
2606 plan year:

2607 (A) employed an average of at least 100 eligible employees on each business day
2608 during the preceding calendar year; and

2609 (B) employs at least two employees on the first day of the plan year.

2610 (ii) "Producer" includes:

2611 (A) a producer;

2612 (B) an affiliate of a producer; or

2613 (C) a consultant.

2614 (b) A producer may not accept or receive any compensation from an insurer or third
2615 party administrator for the initial placement of a health benefit plan, other than a hospital
2616 confinement indemnity policy, unless prior to a large customer's initial purchase of the health
2617 benefit plan the producer discloses in writing to the large customer that the producer will
2618 receive compensation from the insurer or third party administrator for the placement of
2619 insurance, including the amount or type of compensation known to the producer at the time of
2620 the disclosure.

2621 (c) A producer shall:

2622 (i) obtain the large customer's signed acknowledgment that the disclosure under

2623 Subsection (4)(b) was made to the large customer; or

2624 (ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to

2625 the large customer; and

2626 (B) keep the signed statement on file in the producer's office while the health benefit

2627 plan placed with the large customer is in force.

2628 (d) A licensee who collects or receives any part of the compensation from an insurer or

2629 third party administrator in a manner that facilitates an audit shall, while the health benefit plan

2630 placed with the large customer is in force, maintain a copy of:

2631 (i) the signed acknowledgment described in Subsection (4)(c)(i); or

2632 (ii) the signed statement described in Subsection (4)(c)(ii).

2633 (e) Subsection (4)(c) does not apply to:

2634 (i) a person licensed as a producer who acts only as an intermediary between an insurer

2635 and the customer's producer, including a managing general agent; or

2636 (ii) the placement of insurance in a secondary or residual market.

2637 (f) (i) A producer shall provide to a large customer listed in this Subsection (4)(f) an

2638 annual accounting, as defined by rule made by the department in accordance with Title 63G,

2639 Chapter 3, Utah Administrative Rulemaking Act, of all amounts the producer receives in

2640 commission compensation from an insurer or third party administrator as a result of the sale or

2641 placement of a health benefit plan to a large customer that is:

2642 (A) the state;

2643 (B) a political subdivision or instrumentality of the state or a combination thereof

2644 primarily engaged in educational activities or the administration or servicing of educational

2645 activities, including the State Board of Education and its instrumentalities, an institution of

2646 higher education and its branches, a school district and its instrumentalities, a vocational and

2647 technical school, and an entity arising out of a consolidation agreement between entities

2648 described under this Subsection (4)(f)(i)(B);

2649 (C) a county, city, town, local district under Title 17B, Limited Purpose Local
2650 Government Entities - Local Districts, special service district under Title 17D, Chapter 1,
2651 Special Service District Act, an entity created by an interlocal cooperation agreement under
2652 Title 11, Chapter 13, Interlocal Cooperation Act, or any other governmental entity designated
2653 in statute as a political subdivision of the state; or

2654 (D) a quasi-public corporation, that has the same meaning as defined in Section
2655 [63E-1-102](#).

2656 (ii) The department shall pattern the annual accounting required by this Subsection
2657 (4)(f) on the insurance related information on Internal Revenue Service Form 5500 and its
2658 relevant attachments.

2659 (g) At the request of the department, a producer shall provide the department a copy of:

2660 (i) a disclosure required by this Subsection (4); or

2661 (ii) an Internal Revenue Service Form 5500 and its relevant attachments.

2662 (5) This section does not alter the right of any licensee to recover from an insured the
2663 amount of any premium due for insurance effected by or through that licensee or to charge a
2664 reasonable rate of interest upon past-due accounts.

2665 (6) This section does not apply to bail bond producers or bail enforcement agents as
2666 defined in Section [31A-35-102](#).

2667 (7) A licensee may not receive noncommission compensation from an insurer, insured,
2668 or enrollee for providing a service or engaging in an act that is required to be provided or
2669 performed in order to receive commission compensation, except for the surplus lines
2670 transactions that do not receive commissions.

2671 Section 41. Section **31A-23b-102** is amended to read:

2672 **31A-23b-102. Definitions.**

2673 As used in this chapter:

2674 [~~(1) "Compensation" is as defined in:~~]

2675 [~~(a)~~ Subsections ~~31A-23a-501~~(1)(a), (b), and (d); and]
2676 [~~(b)~~ PPACA.]
2677 [~~(2)~~] (1) "Enroll" and "enrollment" mean to:
2678 (a) (i) obtain personally identifiable information about an individual; and
2679 (ii) inform an individual about accident and health insurance plans or public programs
2680 offered on an exchange;
2681 (b) solicit insurance; or
2682 (c) submit to the exchange:
2683 (i) personally identifiable information about an individual; and
2684 (ii) an individual's selection of a particular accident and health insurance plan or public
2685 program offered on the exchange.
2686 [~~(3)~~] (2) (a) "Exchange" means an online marketplace that is certified by the United
2687 States Department of Health and Human Services as either a state-based small employer
2688 exchange or a federally facilitated individual exchange under PPACA.
2689 (b) "Exchange" does not include an online marketplace for the purchase of health
2690 insurance if the online marketplace is not a certified exchange in accordance with Subsection
2691 [~~(3)~~] (2)(a).
2692 [~~(4)~~] (3) "Navigator":
2693 (a) means a person who facilitates enrollment in an exchange by offering to assist, or
2694 who advertises any services to assist, with:
2695 (i) the selection of and enrollment in a qualified health plan or a public program
2696 offered on an exchange; or
2697 (ii) applying for premium subsidies through an exchange; and
2698 (b) includes a person who is an in-person assister or a certified application counselor as
2699 described in federal regulations or guidance issued under PPACA.
2700 [~~(5)~~] (4) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.
2701 [~~(6)~~] (5) "Public programs" means the state Medicaid program in Title 26, Chapter 18,

2702 Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

2703 ~~[(7)]~~ (6) "Resident" is as defined by rule made by the commissioner in accordance with
2704 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2705 ~~[(8)]~~ (7) "Solicit" is as defined in Section 31A-23a-102.

2706 Section 42. Section 31A-23b-202.5 is amended to read:

2707 **31A-23b-202.5. License types.**

2708 (1) A license issued under this chapter shall be issued under the license types described
2709 in Subsection (2).

2710 (2) A license type under this chapter shall be a navigator line of authority or a certified
2711 application counselor line of authority. A license type is intended to describe the matters to be
2712 considered under any education, examination, and training required of an applicant under this
2713 chapter.

2714 (3) (a) A navigator line of authority includes the enrollment process as described in
2715 Subsection 31A-23b-102~~[(4)]~~(3)(a).

2716 (b) (i) A certified application counselor line of authority is limited to providing
2717 information and assistance to individuals and employees about public programs and premium
2718 subsidies available through the exchange.

2719 (ii) A certified application counselor line of authority does not allow the certified
2720 application counselor to assist a person with the selection of or enrollment in a qualified health
2721 plan offered on an exchange.

2722 Section 43. Section 31A-23b-209 is amended to read:

2723 **31A-23b-209. Agency designations.**

2724 (1) An organization shall be licensed as a navigator agency if the organization acts as a
2725 navigator.

2726 (2) A navigator agency that does business in the state shall designate an individual who
2727 is licensed under this chapter to act on the agency's behalf.

2728 (3) A navigator agency shall report to the commissioner, at intervals and in the form

2729 the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah
2730 Administrative Rulemaking Act:

- 2731 (a) a new designation under Subsection (2); and
- 2732 (b) a terminated designation under Subsection (2).

2733 (4) A navigator agency shall notify an individual designee that the individual's
2734 designation is terminated by the agency and of the reason for termination at an interval and in
2735 the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3,
2736 Utah Administrative Rulemaking Act.

2737 ~~(4)~~ (5) (a) A navigator agency licensed under this chapter shall report to the
2738 commissioner the cause of termination of a designation if:

- 2739 (i) the reason for termination is a reason described in Subsection 31A-23b-401(4)(b);
- 2740 or

2741 (ii) the navigator agency has knowledge that the individual licensee engaged in an
2742 activity described in Subsection 31A-23b-401(4)(b) by:

- 2743 (A) a court;
- 2744 (B) a government body; or
- 2745 (C) a self-regulatory organization, which the commissioner may define by rule made in
2746 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2747 (b) The information provided to the commissioner under Subsection ~~(4)~~ (5)(a) is a
2748 private record under Title 63G, Chapter 2, Government Records Access and Management Act.

2749 (c) A navigator agency is immune from civil action, civil penalty, or damages if the
2750 agency complies in good faith with this Subsection ~~(4)~~ (5) by reporting to the commissioner
2751 the cause of termination of a designation.

2752 (d) A navigator agency is not immune from an action or resulting penalty imposed on
2753 the reporting agency as a result of proceedings brought by or on behalf of the department if the
2754 action is based on evidence other than the report submitted in compliance with this Subsection
2755 ~~(4)~~ (5).

2756 ~~[(5)]~~ (6) A navigator agency licensed under this chapter may act in a capacity for which
2757 it is licensed only through an individual who is licensed under this chapter to act in the same
2758 capacity.

2759 ~~[(6)]~~ (7) A navigator agency licensed under this chapter shall designate and report to
2760 the commissioner, in accordance with any rule made by the commissioner pursuant to Title
2761 63G, Chapter 3, Utah Administrative Rulemaking Act, the name of the designated responsible
2762 licensed individual who has authority to act on behalf of the navigator agency in the matters
2763 pertaining to compliance with this title and orders of the commissioner.

2764 ~~[(7)]~~ (8) If a navigator agency has a contract with or designates a licensee in reports
2765 submitted under Subsection (3) or ~~[(6)]~~ (7), there is a rebuttable presumption that the
2766 contracted or designated licensee acts on behalf of the navigator agency.

2767 ~~[(8)]~~ (9) (a) When a license is held by a navigator agency, both the navigator agency
2768 itself and any individual contracted or designated under the navigator agency license are
2769 considered the holders of the navigator agency license for purposes of this section.

2770 (b) If an individual contracted or designated under the navigator agency license
2771 commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting
2772 the navigator agency license, or assessing a forfeiture under Subsection 31A-2-308(1)(b)(i) or
2773 (1)(c)(i), the commissioner may assess a forfeiture, suspend, revoke, or limit the license of, or
2774 take a combination of these actions against:

2775 (i) the individual;

2776 (ii) the navigator agency, if the navigator agency:

2777 (A) is reckless or negligent in its supervision of the individual; or

2778 (B) knowingly participates in the act or failure to act that is the ground for suspending,
2779 revoking, or limiting the license, or assessing a forfeiture; or

2780 (iii) (A) the individual; and

2781 (B) the navigator agency, if the agency meets the requirements of Subsection ~~[(8)]~~

2782 (9)(b)(ii).

2783 Section 44. Section **31A-23b-210** is amended to read:

2784 **31A-23b-210. Place of business and residence address -- Records.**

2785 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:

2786 (i) the address and the one or more telephone numbers of the licensee's principal place
2787 of business; and

2788 (ii) a valid business email address at which the commissioner may contact the licensee.

2789 (b) If a licensee is an individual, in addition to complying with Subsection (1)(a), the
2790 individual shall register and maintain with the commissioner the individual's residence address
2791 and telephone number.

2792 (c) A licensee shall notify the commissioner within 30 days of a change of any of the
2793 following required to be registered with the commissioner under this section:

2794 (i) an address;

2795 (ii) a telephone number; or

2796 (iii) a business email address.

2797 (2) Except as provided under Subsection (3), a licensee under this chapter shall keep at
2798 the principal place of business address registered under Subsection (1), separate and distinct
2799 books and records of the transactions consummated under the Utah license.

2800 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can
2801 be obtained immediately from a central storage place or elsewhere by online computer
2802 terminals located at the registered address.

2803 (4) (a) The books and records maintained under Subsection (2) shall be available for
2804 the inspection by the commissioner during the business hours for a period of time after the date
2805 of the transaction as specified by the commissioner by rule, but in no case for less than the
2806 current calendar year plus three years.

2807 (b) Discarding books and records after the applicable record retention period has
2808 expired does not place the licensee in violation of a later-adopted longer record retention
2809 period.

2810 Section 45. Section **31A-23b-401** is amended to read:
2811 **31A-23b-401. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
2812 **terminating a license -- Rulemaking for renewal or reinstatement.**
2813 (1) A license as a navigator under this chapter remains in force until:
2814 (a) revoked or suspended under Subsection (4);
2815 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
2816 administrative action;
2817 (c) the licensee dies or is adjudicated incompetent as defined under:
2818 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
2819 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
2820 Minors;
2821 (d) lapsed under this section; or
2822 (e) voluntarily surrendered.
2823 (2) The following may be reinstated within one year after the day on which the license
2824 is no longer in force:
2825 (a) a lapsed license; or
2826 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
2827 not be reinstated after the license period in which the license is voluntarily surrendered.
2828 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
2829 license, submission and acceptance of a voluntary surrender of a license does not prevent the
2830 department from pursuing additional disciplinary or other action authorized under:
2831 (a) this title; or
2832 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
2833 Administrative Rulemaking Act.
2834 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an
2835 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
2836 commissioner may:

- 2837 (i) revoke a license;
- 2838 (ii) suspend a license for a specified period of 12 months or less;
- 2839 (iii) limit a license in whole or in part; [or]
- 2840 (iv) deny a license application[-];
- 2841 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
- 2842 (vi) take a combination of actions under Subsections (4)(a)(i) through (iv) and
- 2843 Subsection (4)(a)(v).
- 2844 (b) The commissioner may take an action described in Subsection (4)(a) if the
- 2845 commissioner finds that the licensee:
- 2846 (i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or
- 2847 31A-23b-206;
- 2848 (ii) violated:
- 2849 (A) an insurance statute;
- 2850 (B) a rule that is valid under Subsection 31A-2-201(3); or
- 2851 (C) an order that is valid under Subsection 31A-2-201(4);
- 2852 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
- 2853 delinquency proceedings in any state;
- 2854 (iv) failed to pay a final judgment rendered against the person in this state within 60
- 2855 days after the day on which the judgment became final;
- 2856 (v) refused:
- 2857 (A) to be examined; or
- 2858 (B) to produce its accounts, records, and files for examination;
- 2859 (vi) had an officer who refused to:
- 2860 (A) give information with respect to the navigator's affairs; or
- 2861 (B) perform any other legal obligation as to an examination;
- 2862 (vii) provided information in the license application that is:
- 2863 (A) incorrect;

- 2864 (B) misleading;
- 2865 (C) incomplete; or
- 2866 (D) materially untrue;
- 2867 (viii) violated an insurance law, valid rule, or valid order of another regulatory agency
- 2868 in any jurisdiction;
- 2869 (ix) obtained or attempted to obtain a license through misrepresentation or fraud;
- 2870 (x) improperly withheld, misappropriated, or converted money or properties received
- 2871 in the course of doing insurance business;
- 2872 (xi) intentionally misrepresented the terms of an actual or proposed:
- 2873 (A) insurance contract;
- 2874 (B) application for insurance; or
- 2875 (C) application for public program;
- 2876 (xii) is convicted of a felony;
- 2877 (xiii) admitted or is found to have committed an insurance unfair trade practice or
- 2878 fraud;
- 2879 (xiv) in the conduct of business in this state or elsewhere:
- 2880 (A) used fraudulent, coercive, or dishonest practices; or
- 2881 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 2882 (xv) had an insurance license, navigator license, or its equivalent, denied, suspended,
- 2883 or revoked in another state, province, district, or territory;
- 2884 (xvi) forged another's name to:
- 2885 (A) an application for insurance;
- 2886 (B) a document related to an insurance transaction;
- 2887 (C) a document related to an application for a public program; or
- 2888 (D) a document related to an application for premium subsidies;
- 2889 (xvii) improperly used notes or another reference material to complete an examination
- 2890 for a license;

2891 (xviii) knowingly accepted insurance business from an individual who is not licensed;
2892 (xix) failed to comply with an administrative or court order imposing a child support
2893 obligation;
2894 (xx) failed to:
2895 (A) pay state income tax; or
2896 (B) comply with an administrative or court order directing payment of state income
2897 tax;
2898 (xxi) violated or permitted others to violate the federal Violent Crime Control and Law
2899 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
2900 prohibited from engaging in the business of insurance; or
2901 (xxii) engaged in a method or practice in the conduct of business that endangered the
2902 legitimate interests of customers and the public.
2903 (c) For purposes of this section, if a license is held by an agency, both the agency itself
2904 and any individual designated under the license are considered to be the holders of the license.
2905 (d) If an individual designated under the agency license commits an act or fails to
2906 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
2907 the commissioner may suspend, revoke, or limit the license of:
2908 (i) the individual;
2909 (ii) the agency, if the agency:
2910 (A) is reckless or negligent in its supervision of the individual; or
2911 (B) knowingly participates in the act or failure to act that is the ground for suspending,
2912 revoking, or limiting the license; or
2913 (iii) (A) the individual; and
2914 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).
2915 (5) A licensee under this chapter is subject to the penalties for acting as a licensee
2916 without a license if:
2917 (a) the licensee's license is:

2918 (i) revoked;

2919 (ii) suspended;

2920 (iii) surrendered in lieu of administrative action;

2921 (iv) lapsed; or

2922 (v) voluntarily surrendered; and

2923 (b) the licensee:

2924 (i) continues to act as a licensee; or

2925 (ii) violates the terms of the license limitation.

2926 (6) A licensee under this chapter shall immediately report to the commissioner:

2927 (a) a revocation, suspension, or limitation of the person's license in another state, the

2928 District of Columbia, or a territory of the United States;

2929 (b) the imposition of a disciplinary sanction imposed on that person by another state,

2930 the District of Columbia, or a territory of the United States; or

2931 (c) a judgment or injunction entered against that person on the basis of conduct

2932 involving:

2933 (i) fraud;

2934 (ii) deceit;

2935 (iii) misrepresentation; or

2936 (iv) a violation of an insurance law or rule.

2937 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a

2938 license in lieu of administrative action may specify a time, not to exceed five years, within

2939 which the former licensee may not apply for a new license.

2940 (b) If no time is specified in an order or agreement described in Subsection (7)(a), the

2941 former licensee may not apply for a new license for five years from the day on which the order

2942 or agreement is made without the express approval of the commissioner.

2943 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of

2944 a license issued under this chapter if so ordered by a court.

2945 (9) The commissioner shall by rule prescribe the license renewal and reinstatement
2946 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2947 Section 46. Section **31A-26-209** is amended to read:

2948 **31A-26-209. Form and contents of license.**

2949 (1) Licenses issued under this chapter shall be in the form the commissioner prescribes
2950 and shall set forth:

2951 (a) the name, address, and the one or more telephone [number] numbers of the
2952 licensee;

2953 (b) the license classifications under Section **31A-26-204**;

2954 (c) the date of license issuance; and

2955 (d) any other information the commissioner considers advisable.

2956 (2) An adjuster doing business under any other name than the adjuster's legal name
2957 shall notify the commissioner prior to using the assumed name in this state.

2958 (3) (a) An organization shall be licensed as an agency if the organization acts as:

2959 (i) an independent adjuster; or

2960 (ii) a public adjuster.

2961 (b) The agency license issued under Subsection (3)(a) shall set forth the names of all
2962 natural persons licensed under this chapter who are authorized to act in those capacities for the
2963 organization in this state.

2964 Section 47. Section **31A-26-210** is amended to read:

2965 **31A-26-210. Reports from organizations licensed as adjusters.**

2966 (1) An organization licensed as an adjuster under Section **31A-26-203** shall designate
2967 an individual who has an individual adjuster license to act on the organization's behalf in order
2968 for the licensee to do business for the organization in this state.

2969 (2) An organization licensed under this chapter shall report to the commissioner, at
2970 intervals and in the form the commissioner establishes by rule, made in accordance with Title
2971 63G, Chapter 3, Utah Administrative Rulemaking Act:

2972 (a) a new designation; and
2973 (b) a terminated designation.
2974 (3) An organization licensed under this chapter shall notify an individual licensee that
2975 the individual's designation has been terminated by the organization and of the reason for the
2976 termination at an interval and in the form the commissioner establishes by rule made in
2977 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2978 [~~3~~] (4) (a) An organization licensed under this chapter shall report to the
2979 commissioner the cause of termination of a designation if:
2980 (i) the reason for termination is a reason described in Subsection 31A-26-213(5)(b); or
2981 (ii) the organization has knowledge that the individual licensee is found to have
2982 engaged in an activity described in Subsection 31A-26-213(5)(b) by:
2983 (A) a court;
2984 (B) a government body; or
2985 (C) a self-regulatory organization, which the commissioner may define by rule made in
2986 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2987 (b) The information provided the commissioner under Subsection [~~3~~] (4)(a) is a
2988 private record under Title 63G, Chapter 2, Government Records Access and Management Act.
2989 (c) An organization is immune from civil action, civil penalty, or damages if the
2990 organization complies in good faith with this Subsection [~~3~~] (4) in reporting to the
2991 commissioner the cause of termination of a designation.
2992 (d) Notwithstanding any other provision in this section, an organization is not immune
2993 from an action or resulting penalty imposed on the reporting organization as a result of a
2994 proceeding brought by or on behalf of the department if the action is based on evidence other
2995 than the report submitted in compliance with this Subsection [~~3~~] (4).
2996 [~~4~~] (5) An organization licensed under this chapter may act in a capacity for which it
2997 is licensed only through an individual who is licensed under this chapter to act in the same
2998 capacity.

2999 [~~(5)~~] (6) An organization licensed under this chapter shall designate and report
3000 promptly to the commissioner the name of the designated responsible licensed individual who
3001 has authority to act on behalf of the organization in all matters pertaining to compliance with
3002 this title and orders of the commissioner.

3003 [~~(6)~~] (7) If an agency has a contract with or designates a licensee in a report submitted
3004 under Subsection (2) or [~~(5)~~] (6), there is a rebuttable presumption that the contracted or
3005 designated licensee acts on behalf of the agency.

3006 [~~(7)~~] (8) (a) When a license is held by an organization, both the organization itself and
3007 an individual contracted or designated under the license shall, for purposes of this section, be
3008 considered to be the holders of the organization license.

3009 (b) If an individual designated under the organization license commits an act or fails to
3010 perform a duty that is a ground for suspending, revoking, or limiting the organization license,
3011 the commissioner may assess a forfeiture against, suspend, revoke, or limit the license of, or
3012 take a combination of these actions against:

3013 (i) that individual;

3014 (ii) the organization, if the organization:

3015 (A) is reckless or negligent in its supervision of the individual; or

3016 (B) knowingly participates in the act or failure to act that is the ground for assessing a
3017 forfeiture or suspending, revoking, or limiting the license; or

3018 (iii) (A) the individual; and

3019 (B) the organization, if the organization meets the requirements of Subsection [~~(7)~~]

3020 (8)(b)(ii).

3021 Section 48. Section **31A-26-213** is amended to read:

3022 **31A-26-213. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
3023 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**

3024 (1) A license type issued under this chapter remains in force until:

3025 (a) revoked or suspended under Subsection (5);

- 3026 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
- 3027 administrative action;
- 3028 (c) the licensee dies or is adjudicated incompetent as defined under:
- 3029 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
- 3030 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
- 3031 Minors;
- 3032 (d) lapsed under Section [31A-26-214.5](#); or
- 3033 (e) voluntarily surrendered.
- 3034 (2) The following may be reinstated within one year after the day on which the license
- 3035 is no longer in force:
- 3036 (a) a lapsed license; or
- 3037 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
- 3038 not be reinstated after the license period in which it is voluntarily surrendered.
- 3039 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
- 3040 license, submission and acceptance of a voluntary surrender of a license does not prevent the
- 3041 department from pursuing additional disciplinary or other action authorized under:
- 3042 (a) this title; or
- 3043 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
- 3044 Administrative Rulemaking Act.
- 3045 (4) A license classification issued under this chapter remains in force until:
- 3046 (a) the qualifications pertaining to a license classification are no longer met by the
- 3047 licensee; or
- 3048 (b) the supporting license type:
- 3049 (i) is revoked or suspended under Subsection (5); or
- 3050 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
- 3051 administrative action.
- 3052 (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an

3053 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
3054 commissioner may:

3055 (i) revoke:

3056 (A) a license; or

3057 (B) a license classification;

3058 (ii) suspend for a specified period of 12 months or less:

3059 (A) a license; or

3060 (B) a license classification;

3061 (iii) limit in whole or in part:

3062 (A) a license; or

3063 (B) a license classification; [or]

3064 (iv) deny a license application[-];

3065 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

3066 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and

3067 Subsection (5)(a)(v).

3068 (b) The commissioner may take an action described in Subsection (5)(a) if the
3069 commissioner finds that the licensee:

3070 (i) is unqualified for a license or license classification under Section 31A-26-202,
3071 31A-26-203, 31A-26-204, or 31A-26-205;

3072 (ii) has violated:

3073 (A) an insurance statute;

3074 (B) a rule that is valid under Subsection 31A-2-201(3); or

3075 (C) an order that is valid under Subsection 31A-2-201(4);

3076 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
3077 delinquency proceedings in any state;

3078 (iv) fails to pay a final judgment rendered against the person in this state within 60
3079 days after the judgment became final;

- 3080 (v) fails to meet the same good faith obligations in claims settlement that is required of
- 3081 admitted insurers;
- 3082 (vi) is affiliated with and under the same general management or interlocking
- 3083 directorate or ownership as another insurance adjuster that transacts business in this state
- 3084 without a license;
- 3085 (vii) refuses:
- 3086 (A) to be examined; or
- 3087 (B) to produce its accounts, records, and files for examination;
- 3088 (viii) has an officer who refuses to:
- 3089 (A) give information with respect to the insurance adjuster's affairs; or
- 3090 (B) perform any other legal obligation as to an examination;
- 3091 (ix) provides information in the license application that is:
- 3092 (A) incorrect;
- 3093 (B) misleading;
- 3094 (C) incomplete; or
- 3095 (D) materially untrue;
- 3096 (x) has violated an insurance law, valid rule, or valid order of another regulatory
- 3097 agency in any jurisdiction;
- 3098 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 3099 (xii) has improperly withheld, misappropriated, or converted money or properties
- 3100 received in the course of doing insurance business;
- 3101 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 3102 (A) insurance contract; or
- 3103 (B) application for insurance;
- 3104 (xiv) has been convicted of a felony;
- 3105 (xv) has admitted or been found to have committed an insurance unfair trade practice
- 3106 or fraud;

- 3107 (xvi) in the conduct of business in this state or elsewhere has:
- 3108 (A) used fraudulent, coercive, or dishonest practices; or
- 3109 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 3110 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in
- 3111 any other state, province, district, or territory;
- 3112 (xviii) has forged another's name to:
- 3113 (A) an application for insurance; or
- 3114 (B) a document related to an insurance transaction;
- 3115 (xix) has improperly used notes or any other reference material to complete an
- 3116 examination for an insurance license;
- 3117 (xx) has knowingly accepted insurance business from an individual who is not
- 3118 licensed;
- 3119 (xxi) has failed to comply with an administrative or court order imposing a child
- 3120 support obligation;
- 3121 (xxii) has failed to:
- 3122 (A) pay state income tax; or
- 3123 (B) comply with an administrative or court order directing payment of state income
- 3124 tax;
- 3125 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and
- 3126 Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
- 3127 prohibited from engaging in the business of insurance; or
- 3128 (xxiv) has engaged in methods and practices in the conduct of business that endanger
- 3129 the legitimate interests of customers and the public.
- 3130 (c) For purposes of this section, if a license is held by an agency, both the agency itself
- 3131 and any individual designated under the license are considered to be the holders of the license.
- 3132 (d) If an individual designated under the agency license commits an act or fails to
- 3133 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,

3134 the commissioner may suspend, revoke, or limit the license of:

3135 (i) the individual;

3136 (ii) the agency, if the agency:

3137 (A) is reckless or negligent in its supervision of the individual; or

3138 (B) knowingly participated in the act or failure to act that is the ground for suspending,

3139 revoking, or limiting the license; or

3140 (iii) (A) the individual; and

3141 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

3142 (6) A licensee under this chapter is subject to the penalties for conducting an insurance

3143 business without a license if:

3144 (a) the licensee's license is:

3145 (i) revoked;

3146 (ii) suspended;

3147 (iii) limited;

3148 (iv) surrendered in lieu of administrative action;

3149 (v) lapsed; or

3150 (vi) voluntarily surrendered; and

3151 (b) the licensee:

3152 (i) continues to act as a licensee; or

3153 (ii) violates the terms of the license limitation.

3154 (7) A licensee under this chapter shall immediately report to the commissioner:

3155 (a) a revocation, suspension, or limitation of the person's license in any other state, the

3156 District of Columbia, or a territory of the United States;

3157 (b) the imposition of a disciplinary sanction imposed on that person by any other state,

3158 the District of Columbia, or a territory of the United States; or

3159 (c) a judgment or injunction entered against that person on the basis of conduct

3160 involving:

- 3161 (i) fraud;
- 3162 (ii) deceit;
- 3163 (iii) misrepresentation; or
- 3164 (iv) a violation of an insurance law or rule.

3165 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
3166 license in lieu of administrative action may specify a time not to exceed five years within
3167 which the former licensee may not apply for a new license.

3168 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the
3169 former licensee may not apply for a new license for five years without the express approval of
3170 the commissioner.

3171 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
3172 a license issued under this part if so ordered by a court.

3173 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
3174 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3175 Section 49. Section **31A-26-312** is enacted to read:

3176 **31A-26-312. Prohibited conduct.**

3177 (1) An independent adjuster or public adjuster may not:

3178 (a) participate directly or indirectly in the reconstruction, repair, or restoration of
3179 damaged property that is the subject of a claim adjusted by the independent adjuster or public
3180 adjuster;

3181 (b) engage in any other activities that may reasonably be construed as presenting a
3182 conflict of interest, including soliciting or accepting remuneration from, or having a financial
3183 interest in, or deriving any direct or indirect financial benefit from, a salvage firm, repair firm,
3184 construction firm, or other firm that obtains business in connection with a claim that the
3185 independent adjuster or public adjuster has a contract or agreement to adjust;

3186 (c) subject to Subsection (2), directly or indirectly solicit employment for an attorney
3187 or enter into a contract with an insured for the primary purpose of referring an insured to an

3188 attorney and without actually performing the services customarily provided by an independent
3189 adjuster or public adjuster;

3190 (d) act on behalf of an attorney in having an insured sign an attorney representation
3191 agreement; or

3192 (e) accept a fee, commission, or other valuable consideration of any nature, regardless
3193 of form or amount, in exchange for the referral by an independent adjuster or public adjuster of
3194 an insured to a third-party person, including an attorney, appraiser, umpire, construction
3195 company, contractor, repair firm, or salvage company.

3196 (2) Subsection (1)(c) may not be construed to prohibit an independent adjuster or
3197 public adjuster from recommending a specific attorney to an insured.

3198 (3) An independent adjuster or public adjuster who violates this section is subject to
3199 Section [31A-2-308](#).

3200 Section 50. Section **31A-26-401** is enacted to read:

3201 **Part 4. Public Adjusters**

3202 **31A-26-401. Required contracts.**

3203 (1) A public adjuster may not, directly or indirectly, act within this state as a public
3204 adjuster without having first entered into a contract, in writing, on a form filed with the
3205 department in accordance with Section [31A-21-201](#), executed in duplicate by the public
3206 adjuster and the insured or the insured's duly authorized representative. A public adjuster may
3207 not use a form of contract that is not filed with the department.

3208 (2) A contract described in Subsection (1) is subject to rescission in accordance with
3209 Section [31A-26-311](#).

3210 (3) (a) A contract described in Subsection (1) shall include a prominently displayed
3211 notice in 12-point boldface type that states "WE REPRESENT THE INSURED ONLY."

3212 (b) The commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah
3213 Administrative Rulemaking Act, may require additional prominently displayed notice
3214 requirements in the contract as the commissioner considers necessary.

3215 (4) A public adjuster shall keep at the public adjuster's principal place of business a
3216 copy of each contract entered into in this state for the current year plus three years, and each
3217 contract shall be available at all times for inspection, without notice, by the commissioner or
3218 the commissioner's authorized representative.

3219 (5) A public adjuster may not enter into a contract with an insured and collect
3220 compensation as provided in the contract without actually performing the services customarily
3221 provided by a licensed public adjuster for the insured.

3222 Section 51. Section **31A-26-402** is enacted to read:

3223 **31A-26-402. Compensation.**

3224 (1) Except as provided by Subsection (2), a public adjuster may receive compensation
3225 for service provided under this chapter consisting of an hourly fee, a flat rate, a percentage of
3226 the total amount paid by an insurer to resolve a claim, or another method of compensation.

3227 (2) (a) A public adjuster may not receive a compensation consisting of a percentage of
3228 the total amount paid by an insurer to resolve a claim on a claim on which the insurer, not later
3229 than 72 hours after the date on which the loss is reported to the insurer, either pays or commits
3230 in writing to pay to the insured the policy limit of the insurance policy.

3231 (b) A public adjuster is entitled to reasonable compensation from the insured for
3232 services provided by the public adjuster on behalf of the insured, based on the time spent on a
3233 claim that is subject to this Subsection (2) and expenses incurred by the public adjuster, until
3234 the claim is paid or the insured receives a written commitment to pay from the insurer.

3235 (3) Except for the payment of compensation by the insured, a person paying proceeds
3236 of a policy of insurance or making a payment affecting an insured's rights under a policy of
3237 insurance shall:

3238 (a) include the insured as a payee on the payment draft or check; and

3239 (b) require the written signature and endorsement of the insured on the payment draft
3240 or check.

3241 (4) A public adjuster may not accept any payment that violates this section

3242 notwithstanding whether the insured gives authorization to the public adjuster. A public
3243 adjuster may not sign and endorse any payment draft or check on behalf of an insured.

3244 Section 52. Section **31A-26-403** is enacted to read:

3245 **31A-26-403. Rulemaking.**

3246 The commissioner may make rules, in accordance with Title 63G, Chapter 3, Utah
3247 Administrative Rulemaking Act:

3248 (1) addressing the forms required by this part;

3249 (2) providing for notice requirements in contracts; and

3250 (3) establishing the scope of a contract a public adjuster enters into with an insured that
3251 the public adjuster represents.

3252 Section 53. Section **31A-30-106** is amended to read:

3253 **31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.**

3254 (1) Premium rates for health benefit plans for individuals under this chapter are subject
3255 to this section.

3256 (a) The index rate for a rating period for any class of business may not exceed the
3257 index rate for any other class of business by more than 20%.

3258 (b) (i) For a class of business, the premium rates charged during a rating period to
3259 covered insureds with similar case characteristics for the same or similar coverage, or the rates
3260 that could be charged to the individual under the rating system for that class of business, may
3261 not vary from the index rate by more than 30% of the index rate except as provided under
3262 Subsection (1)(b)(ii).

3263 (ii) A carrier that offers individual and small employer health benefit plans may use the
3264 small employer index rates to establish the rate limitations for individual policies, even if some
3265 individual policies are rated below the small employer base rate.

3266 (c) The percentage increase in the premium rate charged to a covered insured for a new
3267 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
3268 the following:

3269 (i) the percentage change in the new business premium rate measured from the first day
3270 of the prior rating period to the first day of the new rating period;

3271 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
3272 of less than one year, due to the claim experience, health status, or duration of coverage of the
3273 covered individuals as determined from the rate manual for the class of business of the carrier
3274 offering an individual health benefit plan; and

3275 (iii) any adjustment due to change in coverage or change in the case characteristics of
3276 the covered insured as determined from the rate manual for the class of business of the carrier
3277 offering an individual health benefit plan.

3278 (d) (i) A carrier offering an individual health benefit plan shall apply rating factors,
3279 including case characteristics, consistently with respect to all covered insureds in a class of
3280 business.

3281 (ii) Rating factors shall produce premiums for identical individuals that:

3282 (A) differ only by the amounts attributable to plan design; and

3283 (B) do not reflect differences due to the nature of the individuals assumed to select
3284 particular health benefit ~~[products]~~ plans.

3285 (iii) A carrier offering an individual health benefit plan shall treat all health benefit
3286 plans issued or renewed in the same calendar month as having the same rating period.

3287 (e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted
3288 network provision may not be considered similar coverage to a health benefit plan that does not
3289 use a restricted network provision, provided that use of the restricted network provision results
3290 in substantial difference in claims costs.

3291 (f) A carrier offering a health benefit plan to an individual may not, without prior
3292 approval of the commissioner, use case characteristics other than:

3293 (i) age;

3294 (ii) gender;

3295 (iii) geographic area; and

- 3296 (iv) family composition.
- 3297 (g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3,
- 3298 Utah Administrative Rulemaking Act, to:
 - 3299 (A) implement this chapter;
 - 3300 (B) assure that rating practices used by carriers who offer health benefit plans to
 - 3301 individuals are consistent with the purposes of this chapter; and
 - 3302 (C) promote transparency of rating practices of health benefit plans, except that a
 - 3303 carrier may not be required to disclose proprietary information.
 - 3304 (ii) The rules described in Subsection (1)(g)(i) may include rules that:
 - 3305 (A) assure that differences in rates charged for health benefit [products] plans by
 - 3306 carriers who offer health benefit plans to individuals are reasonable and reflect objective
 - 3307 differences in plan design, not including differences due to the nature of the individuals
 - 3308 assumed to select particular health benefit [products] plans; and
 - 3309 (B) prescribe the manner in which case characteristics may be used by carriers who
 - 3310 offer health benefit plans to individuals.
 - 3311 (h) The commissioner shall revise rules issued for Sections [31A-22-602](#) and
 - 3312 [31A-22-605](#) regarding individual accident and health policy rates to allow rating in accordance
 - 3313 with this section.
 - 3314 (2) For purposes of Subsection (1)(c)(i), if a health benefit [product] plan is a health
 - 3315 benefit [product] plan into which the covered carrier is no longer enrolling new covered
 - 3316 insureds, the covered carrier shall use the percentage change in the base premium rate,
 - 3317 provided that the change does not exceed, on a percentage basis, the change in the new
 - 3318 business premium rate for the most similar health benefit product into which the covered
 - 3319 carrier is actively enrolling new covered insureds.
 - 3320 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of
 - 3321 a class of business.
 - 3322 (b) A covered carrier may not offer to transfer a covered insured into or out of a class

3323 of business unless the offer is made to transfer all covered insureds in the class of business
3324 without regard to:

- 3325 (i) case characteristics;
- 3326 (ii) claim experience;
- 3327 (iii) health status; or
- 3328 (iv) duration of coverage since issue.

3329 (4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the
3330 carrier's principal place of business a complete and detailed description of its rating practices
3331 and renewal underwriting practices, including information and documentation that demonstrate
3332 that the carrier's rating methods and practices are:

- 3333 (i) based upon commonly accepted actuarial assumptions; and
- 3334 (ii) in accordance with sound actuarial principles.

3335 (b) (i) A carrier subject to this section shall file with the commissioner, on or before
3336 April 1 of each year, in a form, manner, and containing such information as prescribed by the
3337 commissioner, an actuarial certification certifying that:

- 3338 (A) the carrier is in compliance with this chapter; and
- 3339 (B) the rating methods of the carrier are actuarially sound.

3340 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the
3341 carrier at the carrier's principal place of business.

3342 (c) A carrier shall make the information and documentation described in this
3343 Subsection (4) available to the commissioner upon request.

3344 (d) Except as provided in Subsection (1)(g) or required by PPACA, a record submitted
3345 to the commissioner under this section shall be maintained by the commissioner as a protected
3346 record under Title 63G, Chapter 2, Government Records Access and Management Act.

3347 Section 54. Section **31A-30-106.1** is amended to read:

3348 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**

3349 (1) Premium rates for small employer health benefit plans under this chapter are

3350 subject to this section.

3351 (2) (a) The index rate for a rating period for any class of business may not exceed the
3352 index rate for any other class of business by more than 20%.

3353 (b) For a class of business, the premium rates charged during a rating period to covered
3354 insureds with similar case characteristics for the same or similar coverage, or the rates that
3355 could be charged to an employer group under the rating system for that class of business, may
3356 not vary from the index rate by more than 30% of the index rate, except when catastrophic
3357 mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

3358 (3) The percentage increase in the premium rate charged to a covered insured for a new
3359 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
3360 the following:

3361 (a) the percentage change in the new business premium rate measured from the first
3362 day of the prior rating period to the first day of the new rating period;

3363 (b) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
3364 of less than one year, due to the claim experience, health status, or duration of coverage of the
3365 covered individuals as determined from the small employer carrier's rate manual for the class of
3366 business, except when catastrophic mental health coverage is selected as provided in
3367 Subsection 31A-22-625(2)(d); and

3368 (c) any adjustment due to change in coverage or change in the case characteristics of
3369 the covered insured as determined for the class of business from the small employer carrier's
3370 rate manual.

3371 (4) (a) Adjustments in rates for claims experience, health status, and duration from
3372 issue may not be charged to individual employees or dependents.

3373 (b) Rating adjustments and factors, including case characteristics, shall be applied
3374 uniformly and consistently to the rates charged for all employees and dependents of the small
3375 employer.

3376 (c) Rating factors shall produce premiums for identical groups that:

- 3377 (i) differ only by the amounts attributable to plan design; and
3378 (ii) do not reflect differences due to the nature of the groups assumed to select
3379 particular health benefit [~~products~~] plans.
- 3380 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the
3381 same calendar month as having the same rating period.
- 3382 (5) A health benefit plan that uses a restricted network provision may not be considered
3383 similar coverage to a health benefit plan that does not use a restricted network provision,
3384 provided that use of the restricted network provision results in substantial difference in claims
3385 costs.
- 3386 (6) The small employer carrier may not use case characteristics other than the
3387 following:
- 3388 (a) age of the employee, in accordance with Subsection (7);
3389 (b) geographic area;
3390 (c) family composition in accordance with Subsection (9);
3391 (d) for plans renewed or effective on or after July 1, 2011, gender of the employee and
3392 spouse;
- 3393 (e) for an individual age 65 and older, whether the employer policy is primary or
3394 secondary to Medicare; and
- 3395 (f) a wellness program, in accordance with Subsection (12).
- 3396 (7) Age limited to:
- 3397 (a) the following age bands:
- 3398 (i) less than 20;
3399 (ii) 20-24;
3400 (iii) 25-29;
3401 (iv) 30-34;
3402 (v) 35-39;
3403 (vi) 40-44;

- 3404 (vii) 45-49;
- 3405 (viii) 50-54;
- 3406 (ix) 55-59;
- 3407 (x) 60-64; and
- 3408 (xi) 65 and above; and
- 3409 (b) a standard slope ratio range for each age band, applied to each family composition
- 3410 tier rating structure under Subsection (9)(b):
- 3411 (i) as developed by the commissioner by administrative rule; and
- 3412 (ii) not to exceed an overall ratio as provided in Subsection (8).
- 3413 (8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:
- 3414 (i) 5:1 for plans renewed or effective before January 1, 2012; and
- 3415 (ii) 6:1 for plans renewed or effective on or after January 1, 2012; and
- 3416 (b) the age slope ratios for each age band may not overlap.
- 3417 (9) Except as provided in Subsection [31A-30-207\(2\)](#), family composition is limited to:
- 3418 (a) an overall ratio of:
- 3419 (i) 5:1 or less for plans renewed or effective before January 1, 2012; and
- 3420 (ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and
- 3421 (b) a tier rating structure that includes:
- 3422 (i) four tiers that include:
- 3423 (A) employee only;
- 3424 (B) employee plus spouse;
- 3425 (C) employee plus a child or children; and
- 3426 (D) a family, consisting of an employee plus spouse, and a child or children;
- 3427 (ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:
- 3428 (A) employee only;
- 3429 (B) employee plus spouse;
- 3430 (C) employee plus one child;

- 3431 (D) employee plus two or more children; and
- 3432 (E) employee plus spouse plus one or more children; or
- 3433 (iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:
- 3434 (A) employee only;
- 3435 (B) employee plus spouse;
- 3436 (C) employee plus one child;
- 3437 (D) employee plus two or more children;
- 3438 (E) employee plus spouse plus one child; and
- 3439 (F) employee plus spouse plus two or more children.
- 3440 (10) If a health benefit plan is a health benefit plan into which the small employer
- 3441 carrier is no longer enrolling new covered insureds, the small employer carrier shall use the
- 3442 percentage change in the base premium rate, provided that the change does not exceed, on a
- 3443 percentage basis, the change in the new business premium rate for the most similar health
- 3444 benefit [~~product~~] plan into which the small employer carrier is actively enrolling new covered
- 3445 insureds.
- 3446 (11) (a) A covered carrier may not transfer a covered insured involuntarily into or out
- 3447 of a class of business.
- 3448 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
- 3449 of business unless the offer is made to transfer all covered insureds in the class of business
- 3450 without regard to:
- 3451 (i) case characteristics;
- 3452 (ii) claim experience;
- 3453 (iii) health status; or
- 3454 (iv) duration of coverage since issue.
- 3455 (12) Notwithstanding Subsection (4)(b), a small employer carrier may:
- 3456 (a) offer a wellness program to a small employer group if:
- 3457 (i) the premium discount to the employer for the wellness program does not exceed

3458 20% of the premium for the small employer group; and
3459 (ii) the carrier offers the wellness program discount uniformly across all small
3460 employer groups;
3461 (b) offer a premium discount as part of a wellness program to individual employees in
3462 a small employer group:
3463 (i) to the extent allowed by federal law; and
3464 (ii) if the employee discount based on the wellness program is offered uniformly across
3465 all small employer groups; and
3466 (c) offer a combination of premium discounts for the employer and the employee,
3467 based on a wellness program, if:
3468 (i) the employer discount complies with Subsection (12)(a); and
3469 (ii) the employee discount complies with Subsection (12)(b).
3470 (13) (a) [~~Each~~] A small employer carrier shall maintain at the small employer carrier's
3471 principal place of business a complete and detailed description of its rating practices and
3472 renewal underwriting practices, including information and documentation that demonstrate that
3473 the small employer carrier's rating methods and practices are:
3474 (i) based upon commonly accepted actuarial assumptions; and
3475 (ii) in accordance with sound actuarial principles.
3476 (b) (i) [~~Each~~] A small employer carrier shall file with the commissioner on or before
3477 April 1 of each year, in a form and manner and containing information as prescribed by the
3478 commissioner, an actuarial certification certifying that:
3479 (A) the small employer carrier is in compliance with this chapter; and
3480 (B) the rating methods of the small employer carrier are actuarially sound.
3481 (ii) A copy of the certification required by Subsection (13)(b)(i) shall be retained by the
3482 small employer carrier at the small employer carrier's principal place of business.
3483 (c) A small employer carrier shall make the information and documentation described
3484 in this Subsection (13) available to the commissioner upon request.

3485 (14) (a) The commissioner shall establish rules in accordance with Title 63G, Chapter
3486 3, Utah Administrative Rulemaking Act, to:

3487 (i) implement this chapter; and

3488 (ii) assure that rating practices used by small employer carriers under this section and
3489 carriers for individual plans under Section 31A-30-106 are consistent with the purposes of this
3490 chapter.

3491 (b) The rules may:

3492 (i) assure that differences in rates charged for health benefit plans by carriers are
3493 reasonable and reflect objective differences in plan design, not including differences due to the
3494 nature of the groups or individuals assumed to select particular health benefit plans; and

3495 (ii) prescribe the manner in which case characteristics may be used by small employer
3496 and individual carriers.

3497 (15) Records submitted to the commissioner under this section shall be maintained by
3498 the commissioner as protected records under Title 63G, Chapter 2, Government Records
3499 Access and Management Act.

3500 Section 55. Section 31A-30-107 is amended to read:

3501 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
3502 **nonrenewal.**

3503 (1) Except as otherwise provided in this section, a small employer health benefit plan is
3504 renewable and continues in force:

3505 (a) with respect to all eligible employees and dependents; and

3506 (b) at the option of the plan sponsor.

3507 (2) A small employer health benefit plan may be discontinued or nonrenewed:

3508 (a) for a network plan, if there is no longer any enrollee under the group health plan
3509 who lives, resides, or works in:

3510 (i) the service area of the covered carrier; or

3511 (ii) the area for which the covered carrier is authorized to do business; or

3512 (b) for coverage made available in the small or large employer market only through an
3513 association, if:

3514 (i) the employer's membership in the association ceases; and

3515 (ii) the coverage is terminated uniformly without regard to any health status-related
3516 factor relating to any covered individual.

3517 (3) A small employer health benefit plan may be discontinued if:

3518 (a) a condition described in Subsection (2) exists;

3519 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay
3520 premiums or contributions in accordance with the terms of the contract;

3521 (c) the plan sponsor:

3522 (i) performs an act or practice that constitutes fraud; or

3523 (ii) makes an intentional misrepresentation of material fact under the terms of the
3524 coverage;

3525 (d) the covered carrier:

3526 (i) elects to discontinue offering a particular small employer health benefit [~~product~~]
3527 plan delivered or issued for delivery in this state; and

3528 (ii) (A) provides notice of the discontinuation in writing:

3529 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

3530 (II) at least 90 days before the date the coverage will be discontinued;

3531 (B) provides notice of the discontinuation in writing:

3532 (I) to the commissioner; and

3533 (II) at least three working days prior to the date the notice is sent to the affected plan
3534 sponsors, employees, and dependents of the plan sponsors or employees;

3535 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all
3536 other small employer health benefit [~~products~~] plans currently being offered by the small
3537 employer carrier in the market; and

3538 (D) in exercising the option to discontinue that [~~product~~] health benefit plan and in

3539 offering the option of coverage in this section, acts uniformly without regard to:

3540 (I) the claims experience of a plan sponsor;

3541 (II) any health status-related factor relating to any covered participant or beneficiary; or

3542 (III) any health status-related factor relating to any new participant or beneficiary who

3543 may become eligible for the coverage; or

3544 (e) the covered carrier:

3545 (i) elects to discontinue all of the covered carrier's small employer health benefit plans

3546 in:

3547 (A) the small employer market;

3548 (B) the large employer market; or

3549 (C) both the small employer and large employer markets; and

3550 (ii) (A) provides notice of the discontinuation in writing:

3551 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

3552 (II) at least 180 days before the date the coverage will be discontinued;

3553 (B) provides notice of the discontinuation in writing:

3554 (I) to the commissioner in each state in which an affected insured individual is known

3555 to reside; and

3556 (II) at least 30 working days prior to the date the notice is sent to the affected plan

3557 sponsors, employees, and the dependents of the plan sponsors or employees;

3558 (C) discontinues and nonrenews all plans issued or delivered for issuance in the

3559 market; and

3560 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).

3561 (4) A small employer health benefit plan may be discontinued or nonrenewed:

3562 (a) if a condition described in Subsection (2) exists; or

3563 (b) except as prohibited by Section [31A-30-206](#), for noncompliance with the insurer's

3564 employer contribution requirements.

3565 (5) A small employer health benefit plan may be nonrenewed:

- 3566 (a) if a condition described in Subsection (2) exists; or
3567 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
3568 minimum participation requirements.
- 3569 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
3570 discontinued if after issuance of coverage the eligible employee:
3571 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
3572 or
3573 (ii) makes an intentional misrepresentation of material fact in connection with the
3574 coverage.
- 3575 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
3576 (i) 12 months after the date of discontinuance; and
3577 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
3578 to reenroll.
- 3579 (c) At the time the eligible employee's coverage is discontinued under Subsection
3580 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
3581 coverage is discontinued.
- 3582 (d) An eligible employee may not be discontinued under this Subsection (6) because of
3583 a fraud or misrepresentation that relates to health status.
- 3584 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
3585 the employer:
- 3586 (a) with respect to coverage provided to an employer member of the association; and
3587 (b) if the small employer health benefit plan is made available by a covered carrier in
3588 the employer market only through:
3589 (i) an association;
3590 (ii) a trust; or
3591 (iii) a discretionary group.
- 3592 (8) A covered carrier may modify a small employer health benefit plan only:

- 3593 (a) at the time of coverage renewal; and
- 3594 (b) if the modification is effective uniformly among all plans with that product.
- 3595 Section 56. Section **31A-30-107.1** is amended to read:
- 3596 **31A-30-107.1. Individual discontinuance and nonrenewal.**
- 3597 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an
- 3598 individual basis is renewable and continues in force:
 - 3599 (i) with respect to all individuals or dependents; and
 - 3600 (ii) at the option of the individual.
- 3601 (b) Subsection (1)(a) applies regardless of:
 - 3602 (i) whether the contract is issued through:
 - 3603 (A) a trust;
 - 3604 (B) an association;
 - 3605 (C) a discretionary group; or
 - 3606 (D) other similar grouping; or
 - 3607 (ii) the situs of delivery of the policy or contract.
- 3608 (2) A health benefit plan may be discontinued or nonrenewed:
 - 3609 (a) for a network plan, if:
 - 3610 (i) the individual no longer lives, resides, or works in:
 - 3611 (A) the service area of the covered carrier; or
 - 3612 (B) the area for which the covered carrier is authorized to do business; and
 - 3613 (ii) coverage is terminated uniformly without regard to any health status-related factor
 - 3614 relating to any covered individual; or
 - 3615 (b) for coverage made available through an association, if:
 - 3616 (i) the individual's membership in the association ceases; and
 - 3617 (ii) the coverage is terminated uniformly without regard to any health status-related
 - 3618 factor of covered individuals.
 - 3619 (3) A health benefit plan may be discontinued if:

- 3620 (a) a condition described in Subsection (2) exists;
- 3621 (b) the individual fails to pay premiums or contributions in accordance with the terms
- 3622 of the health benefit plan, including any timeliness requirements;
- 3623 (c) the individual:
- 3624 (i) performs an act or practice that constitutes fraud in connection with the coverage; or
- 3625 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 3626 coverage;
- 3627 (d) the covered carrier:
- 3628 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or
- 3629 issued for delivery in this state; and
- 3630 (ii) (A) provides notice of the discontinuance in writing:
- 3631 (I) to each individual provided coverage; and
- 3632 (II) at least 90 days before the date the coverage will be discontinued;
- 3633 (B) provides notice of the discontinuation in writing:
- 3634 (I) to the commissioner; and
- 3635 (II) at least three working days prior to the date the notice is sent to the affected
- 3636 individuals;
- 3637 (C) offers to each covered individual on a guaranteed issue basis the option to purchase
- 3638 all other individual health benefit [~~products~~] plans currently being offered by the covered
- 3639 carrier for individuals in that market; and
- 3640 (D) acts uniformly without regard to any health status-related factor of a covered
- 3641 individual or dependent of a covered individual who may become eligible for coverage; or
- 3642 (e) the covered carrier:
- 3643 (i) elects to discontinue all of the covered carrier's health benefit plans in the individual
- 3644 market; and
- 3645 (ii) (A) provides notice of the discontinuation in writing:
- 3646 (I) to each covered individual; and

- 3647 (II) at least 180 days before the date the coverage will be discontinued;
- 3648 (B) provides notice of the discontinuation in writing:
- 3649 (I) to the commissioner in each state in which an affected insured individual is known
- 3650 to reside; and
- 3651 (II) at least 30 working days prior to the date the notice is sent to the affected
- 3652 individuals;
- 3653 (C) discontinues and nonrenews all health benefit plans the covered carrier issues or
- 3654 delivers for issuance in the individual market; and
- 3655 (D) acts uniformly without regard to any health status-related factor of a covered
- 3656 individual or a dependent of a covered individual who may become eligible for coverage.

3657 Section 57. Section **31A-35-103** is amended to read:

3658 **31A-35-103. Exemption from other provisions of this title.**

3659 Bail bond agencies are exempted from:

- 3660 (1) Chapter 3, Department Funding, Fees, and Taxes, except Section **31A-3-103**;
- 3661 (2) Chapter 4, Insurers in General, except Sections **31A-4-102**, **31A-4-103**, **31A-4-104**,
- 3662 and **31A-4-107**;
- 3663 (3) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except Section
- 3664 **31A-5-103**;
- 3665 (4) Chapter 6a, Service Contracts;
- 3666 (5) Chapter 6b, Guaranteed Asset Protection Waiver Act;
- 3667 (6) Chapter 7, Nonprofit Health Service Insurance Corporations;
- 3668 (7) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
- 3669 (8) Chapter 8a, Health Discount Program Consumer Protection Act;
- 3670 (9) Chapter 9, Insurance Fraternal;
- 3671 (10) Chapter 10, Annuities;
- 3672 (11) Chapter 11, Motor Clubs;
- 3673 (12) Chapter 12, State Risk Management Fund;

- 3674 (13) Chapter 13, Employee Welfare Funds and Plans;
- 3675 (14) Chapter 14, Foreign Insurers;
- 3676 (15) Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups;
- 3677 (16) Chapter 16, Insurance Holding Companies;
- 3678 (17) Chapter 17, Determination of Financial Condition;
- 3679 (18) Chapter 18, Investments;
- 3680 (19) Chapter 19a, Utah Rate Regulation Act;
- 3681 (20) Chapter 20, Underwriting Restrictions;
- 3682 (21) Chapter 23b, Navigator License Act;
- 3683 (22) Chapter 25, Third Party Administrators;
- 3684 (23) Chapter 26, Insurance Adjusters;
- 3685 (24) Chapter 27, Delinquency Administrative Action Provisions;
- 3686 (25) Chapter 27a, Insurer Receivership Act;
- 3687 (26) Chapter 28, Guaranty Associations;
- 3688 (27) Chapter 30, Individual, Small Employer, and Group Health Insurance Act;
- 3689 (28) Chapter 31, Insurance Fraud Act;
- 3690 (29) Chapter 32a, Medical Care Savings Account Act;
- 3691 (30) Chapter 33, Workers' Compensation Fund;
- 3692 [~~(31)~~] Chapter 34, Voluntary Health Insurance Purchasing Alliance Act;]
- 3693 [~~(32)~~] (31) Chapter 36, Life Settlements Act;
- 3694 [~~(33)~~] (32) Chapter 37, Captive Insurance Companies Act;
- 3695 [~~(34)~~] (33) Chapter 37a, Special Purpose Financial Captive Insurance Company Act;
- 3696 [~~(35)~~] (34) Chapter 38, Federal Health Care Tax Credit Program Act;
- 3697 [~~(36)~~] (35) Chapter 39, Interstate Insurance Product Regulation Compact;
- 3698 [~~(37)~~] (36) Chapter 40, Professional Employer Organization Licensing Act;
- 3699 [~~(38)~~] (37) Chapter 41, Title Insurance Recovery, Education, and Research Fund Act;
- 3700 [~~(39)~~] (38) Chapter 42, Defined Contribution Risk Adjuster Act; and

3701 [~~(40)~~] (39) Chapter 43, Small Employer Stop-Loss Insurance Act.

3702 Section 58. Section 31A-37-102 is amended to read:

3703 **31A-37-102. Definitions.**

3704 As used in this chapter:

3705 (1) (a) "Affiliated company" means a business entity that because of common
3706 ownership, control, operation, or management is in the same corporate or limited liability
3707 company system as:

3708 [~~(a)~~] (i) a parent;

3709 [~~(b)~~] (ii) an industrial insured; or

3710 [~~(c)~~] (iii) a member organization.

3711 (b) Notwithstanding Subsection (1)(a), the commissioner may issue an order finding
3712 that a business entity is not an affiliated company.

3713 (2) "Alien captive insurance company" means an insurer:

3714 (a) formed to write insurance business for a parent or affiliate of the insurer; and

3715 (b) licensed pursuant to the laws of an alien or foreign jurisdiction that imposes
3716 statutory or regulatory standards:

3717 (i) on a business entity transacting the business of insurance in the alien or foreign
3718 jurisdiction; and

3719 (ii) in a form acceptable to the commissioner.

3720 (3) "Association" means a legal association of two or more persons that has been in
3721 continuous existence for at least one year if:

3722 (a) the association or its member organizations:

3723 (i) own, control, or hold with power to vote all of the outstanding voting securities of
3724 an association captive insurance company incorporated as a stock insurer; or

3725 (ii) have complete voting control over an association captive insurance company
3726 incorporated as a mutual insurer;

3727 (b) the association's member organizations collectively constitute all of the subscribers

3728 of an association captive insurance company formed as a reciprocal insurer; or

3729 (c) the association or its member organizations have complete voting control over an
3730 association captive insurance company formed as a limited liability company.

3731 (4) "Association captive insurance company" means a business entity that insures risks
3732 of:

3733 (a) a member organization of the association;

3734 (b) an affiliate of a member organization of the association; and

3735 (c) the association.

3736 (5) "Branch business" means an insurance business transacted by a branch captive
3737 insurance company in this state.

3738 (6) "Branch captive insurance company" means an alien captive insurance company
3739 that has a certificate of authority from the commissioner to transact the business of insurance in
3740 this state through a captive insurance company that is domiciled outside of this state.

3741 (7) "Branch operation" means a business operation of a branch captive insurance
3742 company in this state.

3743 (8) "Captive insurance company" means any of the following formed or holding a
3744 certificate of authority under this chapter:

3745 (a) a branch captive insurance company;

3746 (b) a pure captive insurance company;

3747 (c) an association captive insurance company;

3748 (d) a sponsored captive insurance company;

3749 (e) an industrial insured captive insurance company, including an industrial insured
3750 captive insurance company formed as a risk retention group captive in this state pursuant to the
3751 provisions of the Federal Liability Risk Retention Act of 1986;

3752 (f) a special purpose captive insurance company; or

3753 (g) a special purpose financial captive insurance company.

3754 (9) "Commissioner" means Utah's Insurance Commissioner or the commissioner's

3755 designee.

3756 (10) "Common ownership and control" means that two or more captive insurance
3757 companies are owned or controlled by the same person or group of persons as follows:

3758 (a) in the case of a captive insurance company that is a stock corporation, the direct or
3759 indirect ownership of 80% or more of the outstanding voting stock of the stock corporation;

3760 (b) in the case of a captive insurance company that is a mutual corporation, the direct
3761 or indirect ownership of 80% or more of the surplus and the voting power of the mutual
3762 corporation;

3763 (c) in the case of a captive insurance company that is a limited liability company, the
3764 direct or indirect ownership by the same member or members of 80% or more of the
3765 membership interests in the limited liability company; or

3766 (d) in the case of a sponsored captive insurance company, a protected cell is a separate
3767 captive insurance company owned and controlled by the protected cell's participant, only if:

3768 (i) the participant is the only participant with respect to the protected cell; and

3769 (ii) the participant is the sponsor or is affiliated with the sponsor of the sponsored
3770 captive insurance company through common ownership and control.

3771 (11) "Consolidated debt to total capital ratio" means the ratio of Subsection (11)(a) to
3772 (b).

3773 (a) This Subsection (11)(a) is an amount equal to the sum of all debts and hybrid
3774 capital instruments including:

3775 (i) all borrowings from depository institutions;

3776 (ii) all senior debt;

3777 (iii) all subordinated debts;

3778 (iv) all trust preferred shares; and

3779 (v) all other hybrid capital instruments that are not included in the determination of
3780 consolidated GAAP net worth issued and outstanding.

3781 (b) This Subsection (11)(b) is an amount equal to the sum of:

3782 (i) total capital consisting of all debts and hybrid capital instruments as described in
3783 Subsection (11)(a); and

3784 (ii) shareholders' equity determined in accordance with generally accepted accounting
3785 principles for reporting to the United States Securities and Exchange Commission.

3786 (12) "Consolidated GAAP net worth" means the consolidated shareholders' or
3787 members' equity determined in accordance with generally accepted accounting principles for
3788 reporting to the United States Securities and Exchange Commission.

3789 (13) "Controlled unaffiliated business" means a business entity:

3790 (a) (i) in the case of a pure captive insurance company, that is not in the corporate or
3791 limited liability company system of a parent or the parent's affiliate; or

3792 (ii) in the case of an industrial insured captive insurance company, that is not in the
3793 corporate or limited liability company system of an industrial insured or an affiliated company
3794 of the industrial insured;

3795 (b) (i) in the case of a pure captive insurance company, that has a contractual
3796 relationship with a parent or affiliate; or

3797 (ii) in the case of an industrial insured captive insurance company, that has a
3798 contractual relationship with an industrial insured or an affiliated company of the industrial
3799 insured; and

3800 (c) whose risks that are or will be insured by a pure captive insurance company, an
3801 industrial insured captive insurance company, or both are managed [~~by one of the following~~] in
3802 accordance with Subsection [31A-37-106](#)(1)(j) by:

3803 (i) (A) a pure captive insurance company; or

3804 [~~(ii)~~] (B) an industrial insured captive insurance company[.]; or

3805 (ii) a parent or affiliate of:

3806 (A) a pure captive insurance company; or

3807 (B) an industrial insured captive insurance company.

3808 (14) "Department" means the Insurance Department.

- 3809 (15) "Industrial insured" means an insured:
- 3810 (a) that produces insurance:
- 3811 (i) by the services of a full-time employee acting as a risk manager or insurance
- 3812 manager; or
- 3813 (ii) using the services of a regularly and continuously qualified insurance consultant;
- 3814 (b) whose aggregate annual premiums for insurance on all risks total at least \$25,000;
- 3815 and
- 3816 (c) that has at least 25 full-time employees.
- 3817 (16) "Industrial insured captive insurance company" means a business entity that:
- 3818 (a) insures risks of the industrial insureds that comprise the industrial insured group;
- 3819 and
- 3820 (b) may insure the risks of:
- 3821 (i) an affiliated company of an industrial insured; or
- 3822 (ii) a controlled unaffiliated business of:
- 3823 (A) an industrial insured; or
- 3824 (B) an affiliated company of an industrial insured.
- 3825 (17) "Industrial insured group" means:
- 3826 (a) a group of industrial insureds that collectively:
- 3827 (i) own, control, or hold with power to vote all of the outstanding voting securities of
- 3828 an industrial insured captive insurance company incorporated or organized as a limited liability
- 3829 company as a stock insurer; or
- 3830 (ii) have complete voting control over an industrial insured captive insurance company
- 3831 incorporated or organized as a limited liability company as a mutual insurer;
- 3832 (b) a group that is:
- 3833 (i) created under the Product Liability Risk Retention Act of 1981, 15 U.S.C. Sec. 3901
- 3834 et seq., as amended, as a corporation or other limited liability association; and
- 3835 (ii) taxable under this title as a:

3836 (A) stock corporation; or
3837 (B) mutual insurer; or
3838 (c) a group that has complete voting control over an industrial captive insurance
3839 company formed as a limited liability company.

3840 (18) "Member organization" means a person that belongs to an association.

3841 (19) "Parent" means a person that directly or indirectly owns, controls, or holds with
3842 power to vote more than 50% of:

3843 (a) the outstanding voting securities of a pure captive insurance company; or

3844 (b) the pure captive insurance company, if the pure captive insurance company is
3845 formed as a limited liability company.

3846 (20) "Participant" means an entity that is insured by a sponsored captive insurance
3847 company:

3848 (a) if the losses of the participant are limited through a participant contract to the assets
3849 of a protected cell; and

3850 (b)(i) the entity is permitted to be a participant under Section 31A-37-403; or

3851 (ii) the entity is an affiliate of an entity permitted to be a participant under Section
3852 31A-37-403.

3853 (21) "Participant contract" means a contract by which a sponsored captive insurance
3854 company:

3855 (a) insures the risks of a participant; and

3856 (b) limits the losses of the participant to the assets of a protected cell.

3857 (22) "Protected cell" means a separate account established and maintained by a
3858 sponsored captive insurance company for one participant.

3859 (23) "Pure captive insurance company" means a business entity that insures risks of a
3860 parent or affiliate of the business entity.

3861 (24) "Special purpose financial captive insurance company" is as defined in Section
3862 31A-37a-102.

3863 (25) "Sponsor" means an entity that:
3864 (a) meets the requirements of Section 31A-37-402; and
3865 (b) is approved by the commissioner to:
3866 (i) provide all or part of the capital and surplus required by applicable law in an amount
3867 of not less than \$350,000, which amount the commissioner may increase by order if the
3868 commissioner considers it necessary; and
3869 (ii) organize and operate a sponsored captive insurance company.

3870 (26) "Sponsored captive insurance company" means a captive insurance company:
3871 (a) in which the minimum capital and surplus required by applicable law is provided by
3872 one or more sponsors;
3873 (b) that is formed or holding a certificate of authority under this chapter;
3874 (c) that insures the risks of a separate participant through the contract; and
3875 (d) that segregates each participant's liability through one or more protected cells.

3876 (27) "Treasury rates" means the United States Treasury strip asked yield as published
3877 in the Wall Street Journal as of a balance sheet date.

3878 Section 59. Section 31A-37-106 is amended to read:

3879 **31A-37-106. Authority to make rules -- Authority to issue orders.**

3880 (1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3881 commissioner may adopt rules to:

3882 (a) determine circumstances under which a branch captive insurance company is not
3883 required to be a pure captive insurance company;

3884 (b) require a statement, document, or information that a captive insurance company
3885 shall provide to the commissioner to obtain a certificate of authority;

3886 (c) determine a factor a captive insurance company shall provide evidence of under
3887 Subsection 31A-37-202(4)(~~c~~)(b);

3888 (d) prescribe one or more capital requirements for a captive insurance company in
3889 addition to those required under Section 31A-37-204 based on the type, volume, and nature of

3890 insurance business transacted by the captive insurance company;

3891 (e) waive or modify a requirement for public notice and hearing for the following by a

3892 captive insurance company:

3893 (i) merger;

3894 (ii) consolidation;

3895 (iii) conversion;

3896 (iv) mutualization;

3897 (v) redomestication; or

3898 (vi) acquisition;

3899 (f) approve the use of one or more reliable methods of valuation and rating for:

3900 (i) an association captive insurance company;

3901 (ii) a sponsored captive insurance company; or

3902 (iii) an industrial insured group;

3903 (g) prohibit or limit an investment that threatens the solvency or liquidity of:

3904 (i) a pure captive insurance company; or

3905 (ii) an industrial insured captive insurance company;

3906 (h) determine the financial reports a sponsored captive insurance company shall

3907 annually file with the commissioner;

3908 (i) prescribe the required forms and reports under Section [31A-37-501](#); and

3909 (j) establish one or more standards to ensure that:

3910 (i) one of the following is able to exercise control of the risk management function of a

3911 controlled unaffiliated business to be insured by a pure captive insurance company:

3912 (A) a parent; or

3913 (B) an affiliated company of a parent; or

3914 (ii) one of the following is able to exercise control of the risk management function of

3915 a controlled unaffiliated business to be insured by an industrial insured captive insurance

3916 company:

3917 (A) an industrial insured; or
3918 (B) an affiliated company of the industrial insured.
3919 (2) Notwithstanding Subsection (1)(j), until the commissioner adopts the rules
3920 authorized under Subsection (1)(j), the commissioner may by temporary order grant authority
3921 to insure risks to:

- 3922 (a) a pure captive insurance company; or
- 3923 (b) an industrial insured captive insurance company.

3924 (3) The commissioner may issue prohibitory, mandatory, and other orders relating to a
3925 captive insurance company as necessary to enable the commissioner to secure compliance with
3926 this chapter.

3927 Section 60. Section **31A-37-202** is amended to read:

3928 **31A-37-202. Permissive areas of insurance.**

3929 (1) (a) Except as provided in Subsection (1)(b), when permitted by its articles of
3930 incorporation, certificate of organization, or charter, a captive insurance company may apply to
3931 the commissioner for a certificate of authority to do all insurance authorized by this title except
3932 workers' compensation insurance.

3933 (b) Notwithstanding Subsection (1)(a):

3934 (i) a pure captive insurance company may not insure a risk other than a risk of:

3935 (A) ~~its~~ the pure captive insurance company's parent or affiliate;

3936 (B) a controlled unaffiliated business; or

3937 (C) a combination of Subsections (1)(b)(i)(A) and (B);

3938 (ii) an association captive insurance company may not insure a risk other than a risk of:

3939 (A) an affiliate;

3940 (B) a member organization of its association; and

3941 (C) an affiliate of a member organization of its association;

3942 (iii) an industrial insured captive insurance company may not insure a risk other than a
3943 risk of:

- 3944 (A) an industrial insured that is part of the industrial insured group;
- 3945 (B) an affiliate of an industrial insured that is part of the industrial insured group; and
- 3946 (C) a controlled unaffiliated business of:
 - 3947 (I) an industrial insured that is part of the industrial insured group; or
 - 3948 (II) an affiliate of an industrial insured that is part of the industrial insured group;
 - 3949 (iv) a special purpose captive insurance company may only insure a risk of its parent;
 - 3950 (v) a captive insurance company may not provide:
 - 3951 (A) personal motor vehicle insurance coverage;
 - 3952 (B) homeowner's insurance coverage; or
 - 3953 (C) a component of a coverage described in this Subsection (1)(b)(v); and
 - 3954 (vi) a captive insurance company may not accept or cede reinsurance except as
 - 3955 provided in Section [31A-37-303](#).
- 3956 (c) Notwithstanding Subsection (1)(b)(iv), for a risk approved by the commissioner a
- 3957 special purpose captive insurance company may provide:
 - 3958 (i) insurance;
 - 3959 (ii) reinsurance; or
 - 3960 (iii) both insurance and reinsurance.
- 3961 (2) To conduct insurance business in this state a captive insurance company shall:
 - 3962 (a) obtain from the commissioner a certificate of authority authorizing it to conduct
 - 3963 insurance business in this state;
 - 3964 (b) hold at least once each year in this state:
 - 3965 (i) a board of directors meeting; or
 - 3966 [~~(ii) in the case of a reciprocal insurer, a subscriber's advisory committee meeting; or~~]
 - 3967 [~~(iii)~~] (ii) in the case of a limited liability company, a meeting of the managers;
 - 3968 (c) maintain in this state:
 - 3969 (i) the principal place of business of the captive insurance company; or
 - 3970 (ii) in the case of a branch captive insurance company, the principal place of business

3971 for the branch operations of the branch captive insurance company; and

3972 (d) except as provided in Subsection (3), appoint a resident registered agent to accept
3973 service of process and to otherwise act on behalf of the captive insurance company in this state.

3974 (3) Notwithstanding Subsection (2)(d), in the case of a captive insurance company
3975 formed as a corporation [~~or a reciprocal insurer~~], if the registered agent cannot with reasonable
3976 diligence be found at the registered office of the captive insurance company, the commissioner
3977 is the agent of the captive insurance company upon whom process, notice, or demand may be
3978 served.

3979 (4) (a) Before receiving a certificate of authority, a captive insurance company:

3980 (i) formed as a corporation shall file with the commissioner:

3981 (A) a certified copy of:

3982 (I) articles of incorporation or the charter of the corporation; and

3983 (II) bylaws of the corporation;

3984 (B) a statement under oath of the president and secretary of the corporation showing
3985 the financial condition of the corporation; and

3986 (C) any other statement or document required by the commissioner under Section
3987 [31A-37-106](#); and

3988 [~~(ii) formed as a reciprocal shall;~~]

3989 [~~(A) file with the commissioner;~~]

3990 [~~(I) a certified copy of the power of attorney of the attorney-in-fact of the reciprocal;~~]

3991 [~~(II) a certified copy of the subscribers' agreement of the reciprocal;~~]

3992 [~~(III) a statement under oath of the attorney-in-fact of the reciprocal showing the
3993 financial condition of the reciprocal; and]~~

3994 [~~(IV) any other statement or document required by the commissioner under Section
3995 [31A-37-106](#); and]~~

3996 [~~(B) submit to the commissioner for approval a description of the;~~]

3997 [~~(I) coverages;~~]

3998 ~~[(H) deductibles;]~~
3999 ~~[(HH) coverage limits;]~~
4000 ~~[(IV) rates; and]~~
4001 ~~[(V) any other information the commissioner requires under Section 31A-37-106; and]~~
4002 ~~[(iii)]~~ (ii) formed as a limited liability company shall file with the commissioner:
4003 (A) a certified copy of the certificate of organization and the operating agreement of
4004 the organization;
4005 (B) a statement under oath of the president and secretary of the organization showing
4006 the financial condition of the organization;
4007 (C) evidence that the limited liability company is manager-managed; and
4008 (D) any other statement or document required by the commissioner under Section
4009 31A-37-106.
4010 ~~[(b) (i) If there is a subsequent material change in an item in the description required~~
4011 ~~under Subsection (4)(a)(ii)(B) for a reciprocal captive insurance company, the reciprocal~~
4012 ~~captive insurance company shall submit to the commissioner for approval an appropriate~~
4013 ~~revision to the description required under Subsection (4)(a)(ii)(B).]~~
4014 ~~[(ii) A reciprocal captive insurance company that is required to submit a revision under~~
4015 ~~Subsection (4)(b)(i) may not offer any additional types of insurance until the commissioner~~
4016 ~~approves a revision of the description.]~~
4017 ~~[(iii) A reciprocal captive insurance company shall inform the commissioner of a~~
4018 ~~material change in a rate within 30 days of the adoption of the change.]~~
4019 ~~[(c)]~~ (b) In addition to the information required by Subsection (4)(a), an applicant
4020 captive insurance company shall file with the commissioner evidence of:
4021 (i) the amount and liquidity of the assets of the applicant captive insurance company
4022 relative to the risks to be assumed by the applicant captive insurance company;
4023 (ii) the adequacy of the expertise, experience, and character of the person who will
4024 manage the applicant captive insurance company;

4025 (iii) the overall soundness of the plan of operation of the applicant captive insurance
4026 company;

4027 (iv) the adequacy of the loss prevention programs for the following of the applicant
4028 captive insurance company:

4029 (A) a parent;

4030 (B) a member organization; or

4031 (C) an industrial insured; and

4032 (v) any other factor the commissioner:

4033 (A) adopts by rule under Section 31A-37-106; and

4034 (B) considers relevant in ascertaining whether the applicant captive insurance company
4035 will be able to meet the policy obligations of the applicant captive insurance company.

4036 ~~[(d)]~~ (c) In addition to the information required by Subsections (4)(a)[;] and (b)[, and
4037 (e);] an applicant sponsored captive insurance company shall file with the commissioner:

4038 (i) a business plan at the level of detail required by the commissioner under Section
4039 31A-37-106 demonstrating:

4040 (A) the manner in which the applicant sponsored captive insurance company will
4041 account for the losses and expenses of each protected cell; and

4042 (B) the manner in which the applicant sponsored captive insurance company will report
4043 to the commissioner the financial history, including losses and expenses, of each protected cell;

4044 (ii) a statement acknowledging that the applicant sponsored captive insurance company
4045 will make all financial records of the applicant sponsored captive insurance company,
4046 including records pertaining to a protected cell, available for inspection or examination by the
4047 commissioner;

4048 (iii) a contract or sample contract between the applicant sponsored captive insurance
4049 company and a participant; and

4050 (iv) evidence that expenses will be allocated to each protected cell in an equitable
4051 manner.

4052 (5) (a) Information submitted pursuant to Subsection (4) is classified as a protected
4053 record under Title 63G, Chapter 2, Government Records Access and Management Act.

4054 (b) Notwithstanding Title 63G, Chapter 2, Government Records Access and
4055 Management Act, the commissioner may disclose information submitted pursuant to
4056 Subsection (4) to a public official having jurisdiction over the regulation of insurance in
4057 another state if:

4058 (i) the public official receiving the information agrees in writing to maintain the
4059 confidentiality of the information; and

4060 (ii) the laws of the state in which the public official serves require the information to be
4061 confidential.

4062 (c) This Subsection (5) does not apply to information provided by an industrial insured
4063 captive insurance company insuring the risks of an industrial insured group.

4064 (6) (a) A captive insurance company shall pay to the department the following
4065 nonrefundable fees established by the department under Sections 31A-3-103, 31A-3-304, and
4066 63J-1-504:

4067 (i) a fee for examining, investigating, and processing, by a department employee, of an
4068 application for a certificate of authority made by a captive insurance company;

4069 (ii) a fee for obtaining a certificate of authority for the year the captive insurance
4070 company is issued a certificate of authority by the department; and

4071 (iii) a certificate of authority renewal fee.

4072 (b) The commissioner may:

4073 (i) assign a department employee or retain legal, financial, and examination services
4074 from outside the department to perform the services described in:

4075 (A) Subsection (6)(a); and

4076 (B) Section 31A-37-502; and

4077 (ii) charge the reasonable cost of services described in Subsection (6)(b)(i) to the
4078 applicant captive insurance company.

4079 (7) If the commissioner is satisfied that the documents and statements filed by the
4080 applicant captive insurance company comply with this chapter, the commissioner may grant a
4081 certificate of authority authorizing the company to do insurance business in this state.

4082 (8) A certificate of authority granted under this section expires annually and shall be
4083 renewed by July 1 of each year.

4084 Section 61. Section **31A-37-204** is amended to read:

4085 **31A-37-204. Paid-in capital -- Other capital.**

4086 (1) (a) The commissioner may not issue a certificate of authority to a company
4087 described in Subsection (1)(c) unless the company possesses and thereafter maintains
4088 unimpaired paid-in capital and unimpaired paid-in surplus of:

4089 (i) in the case of a pure captive insurance company, not less than \$250,000;

4090 (ii) in the case of an association captive insurance company [~~incorporated as a stock~~
4091 ~~insurer~~], not less than \$750,000;

4092 (iii) in the case of an industrial insured captive insurance company incorporated as a
4093 stock insurer, not less than \$700,000;

4094 (iv) in the case of a sponsored captive insurance company, not less than \$1,000,000, of
4095 which a minimum of \$350,000 is provided by the sponsor; or

4096 (v) in the case of a special purpose captive insurance company, an amount determined
4097 by the commissioner after giving due consideration to the company's business plan, feasibility
4098 study, and pro-formas, including the nature of the risks to be insured.

4099 (b) The paid-in capital and surplus required under this Subsection (1) may be in the
4100 form of:

4101 (i) (A) cash; or

4102 (B) cash equivalent;

4103 (ii) an irrevocable letter of credit:

4104 (A) issued by:

4105 (I) a bank chartered by this state; or

- 4106 (II) a member bank of the Federal Reserve System; and
4107 (B) approved by the commissioner; [~~or~~]
4108 (iii) marketable securities as determined by [~~Subsections 31A-18-105(1) and (6).~~]
4109 Subsection (5); or
4110 (iv) some other thing of value approved by the commissioner, for a period not to
4111 exceed 45 days, to facilitate the formation of a captive insurance company in this state pursuant
4112 to an approved plan of liquidation and reorganization of another captive insurance company or
4113 alien captive insurance company in another jurisdiction.
- 4114 (c) This Subsection (1) applies to:
4115 (i) a pure captive insurance company;
4116 (ii) a sponsored captive insurance company;
4117 (iii) a special purpose captive insurance company;
4118 (iv) an association captive insurance company [~~incorporated as a stock insurer~~]; or
4119 (v) an industrial insured captive insurance company [~~incorporated as a stock insurer~~].
- 4120 (2) (a) The commissioner may, under Section ~~31A-37-106~~, prescribe additional capital
4121 based on the type, volume, and nature of insurance business transacted.
- 4122 (b) The capital prescribed by the commissioner under this Subsection (2) may be in the
4123 form of:
4124 (i) cash;
4125 (ii) an irrevocable letter of credit issued by:
4126 (A) a bank chartered by this state; or
4127 (B) a member bank of the Federal Reserve System; or
4128 (iii) marketable securities as determined by [~~Subsections 31A-18-105(1) and (6)~~]
4129 Subsection (5).
- 4130 (3) (a) Except as provided in Subsection (3)(c), a branch captive insurance company, as
4131 security for the payment of liabilities attributable to branch operations, shall, through its branch
4132 operations, establish and maintain a trust fund:

- 4133 (i) funded by an irrevocable letter of credit or other acceptable asset; and
- 4134 (ii) in the United States for the benefit of:
 - 4135 (A) United States policyholders; and
 - 4136 (B) United States ceding insurers under:
 - 4137 (I) insurance policies issued; or
 - 4138 (II) reinsurance contracts issued or assumed.
- 4139 (b) The amount of the security required under this Subsection (3) shall be no less than:
 - 4140 (i) the capital and surplus required by this chapter; and
 - 4141 (ii) the reserves on the insurance policies or reinsurance contracts, including:
 - 4142 (A) reserves for losses;
 - 4143 (B) allocated loss adjustment expenses;
 - 4144 (C) incurred but not reported losses; and
 - 4145 (D) unearned premiums with regard to business written through branch operations.
 - 4146 (c) Notwithstanding the other provisions of this Subsection (3)~~[-]~~:
 - 4147 (i) the commissioner may permit a branch captive insurance company that is required
 - 4148 to post security for loss reserves on branch business by its reinsurer to reduce the funds in the
 - 4149 trust account required by this section by the same amount as the security posted if the security
 - 4150 remains posted with the reinsurer[-]; and
 - 4151 (ii) a branch captive insurance company that is the result of the licensure of an alien
 - 4152 captive insurance company that is not formed in an alien jurisdiction is not subject to the
 - 4153 requirements of this Subsection (3).
- 4154 (4) (a) A captive insurance company may not pay the following without the prior
- 4155 approval of the commissioner:
 - 4156 (i) a dividend out of capital or surplus in excess of the limits under Section
 - 4157 16-10a-640; or
 - 4158 (ii) a distribution with respect to capital or surplus in excess of the limits under Section
 - 4159 16-10a-640.

4160 (b) The commissioner shall condition approval of an ongoing plan for the payment of
4161 dividends or other distributions on the retention, at the time of each payment, of capital or
4162 surplus in excess of:

4163 (i) amounts specified by the commissioner under Section 31A-37-106; or

4164 (ii) determined in accordance with formulas approved by the commissioner under
4165 Section 31A-37-106.

4166 ~~[(5) Notwithstanding Subsection (1), a captive insurance company organized as a~~
4167 ~~reciprocal insurer under this chapter may not be issued a certificate of authority unless the~~
4168 ~~captive insurance company possesses and maintains unimpaired paid-in surplus of \$1,000,000.]~~

4169 ~~[(6) (a) The commissioner may prescribe additional unimpaired paid-in surplus based~~
4170 ~~upon the type, volume, and nature of the insurance business transacted.]~~

4171 ~~[(b) The unimpaired paid-in surplus required under this Subsection (6) may be in the~~
4172 ~~form of an irrevocable letter of credit issued by:]~~

4173 ~~[(i) a bank chartered by this state; or]~~

4174 ~~[(ii) a member bank of the Federal Reserve System.]~~

4175 (5) For purposes of this section, marketable securities means:

4176 (a) a bond or other evidence of indebtedness of a governmental unit in the United
4177 States or Canada or any instrumentality of the United States or Canada; or

4178 (b) securities:

4179 (i) traded on one or more of the following exchanges in the United States:

4180 (A) New York;

4181 (B) American; or

4182 (C) NASDAQ;

4183 (ii) when no particular security, or a substantially related security, applied toward the
4184 required minimum capital and surplus requirement of Subsection (1) represents more than 50%
4185 of the minimum capital and surplus requirement; and

4186 (iii) when no group of up to four particular securities, consolidating substantially

4187 related securities, applied toward the required minimum capital and surplus requirement of
4188 Subsection (1) represents more than 90% of the minimum capital and surplus requirement.

4189 (6) Notwithstanding Subsection (5), to protect the solvency and liquidity of a captive
4190 insurance company, the commissioner may reject the application of specific assets or amounts
4191 of specific assets to satisfying the requirement of Subsection (1).

4192 Section 62. Section **31A-37-301** is amended to read:

4193 **31A-37-301. Formation.**

4194 (1) A pure captive insurance company or a sponsored captive insurance company
4195 formed as a stock insurer shall be incorporated as a stock insurer with the capital of the pure
4196 captive insurance company or sponsored captive insurance company:

4197 (a) divided into shares; and

4198 (b) held by the stockholders of the pure captive insurance company or sponsored
4199 captive insurance company.

4200 (2) A pure captive insurance company or a sponsored captive insurance company
4201 formed as a limited liability company shall be organized as a members' interest insurer with the
4202 capital of the pure captive insurance company or sponsored captive insurance company:

4203 (a) divided into interests; and

4204 (b) held by the members of the pure captive insurance company or sponsored captive
4205 insurance company.

4206 (3) An association captive insurance company or an industrial insured captive
4207 insurance company may be:

4208 (a) incorporated as a stock insurer with the capital of the association captive insurance
4209 company or industrial insured captive insurance company:

4210 (i) divided into shares; and

4211 (ii) held by the stockholders of the association captive insurance company or industrial
4212 insured captive insurance company;

4213 (b) incorporated as a mutual insurer without capital stock, with a governing body

4214 elected by the member organizations of the association captive insurance company or industrial
4215 insured captive insurance company; or

4216 ~~[(c) organized as a reciprocal.]~~

4217 (c) organized as a limited liability company with the capital of the association captive
4218 insurance company or industrial insured captive insurance company:

4219 (i) divided into interests; and

4220 (ii) held by the members of the association captive insurance company or industrial
4221 insured captive insurance company.

4222 (4) A captive insurance company formed as a corporation may not have fewer than
4223 three incorporators of whom one shall be a resident of this state.

4224 (5) A captive insurance company formed as a limited liability company may not have
4225 fewer than three organizers of whom one shall be a resident of this state.

4226 (6) (a) Before a captive insurance company formed as a corporation files the
4227 corporation's articles of incorporation with the Division of Corporations and Commercial
4228 Code, the incorporators shall obtain from the commissioner a certificate finding that the
4229 establishment and maintenance of the proposed corporation will promote the general good of
4230 the state.

4231 (b) In considering a request for a certificate under Subsection (6)(a), the commissioner
4232 shall consider:

4233 (i) the character, reputation, financial standing, and purposes of the incorporators;

4234 (ii) the character, reputation, financial responsibility, insurance experience, and
4235 business qualifications of the officers and directors;

4236 (iii) any information in:

4237 (A) the application for a certificate of authority; or

4238 (B) the department's files; and

4239 (iv) other aspects that the commissioner considers advisable.

4240 (7) (a) Before a captive insurance company formed as a limited liability company files

4241 the limited liability company's certificate of organization with the Division of Corporations and
4242 Commercial Code, the limited liability company shall obtain from the commissioner a
4243 certificate finding that the establishment and maintenance of the proposed limited liability
4244 company will promote the general good of the state.

4245 (b) In considering a request for a certificate under Subsection (7)(a), the commissioner
4246 shall consider:

4247 (i) the character, reputation, financial standing, and purposes of the organizers;

4248 (ii) the character, reputation, financial responsibility, insurance experience, and
4249 business qualifications of the managers;

4250 (iii) any information in:

4251 (A) the application for a certificate of authority; or

4252 (B) the department's files; and

4253 (iv) other aspects that the commissioner considers advisable.

4254 (8) (a) A captive insurance company formed as a corporation shall file with the
4255 Division of Corporations and Commercial Code:

4256 (i) the captive insurance company's articles of incorporation;

4257 (ii) the certificate issued pursuant to Subsection (6); and

4258 (iii) the fees required by the Division of Corporations and Commercial Code.

4259 (b) The Division of Corporations and Commercial Code shall file both the articles of
4260 incorporation and the certificate described in Subsection (6) for a captive insurance company
4261 that complies with this section.

4262 (9) (a) A captive insurance company formed as a limited liability company shall file
4263 with the Division of Corporations and Commercial Code:

4264 (i) the captive insurance company's certificate of organization;

4265 (ii) the certificate issued pursuant to Subsection (7); and

4266 (iii) the fees required by the Division of Corporations and Commercial Code.

4267 (b) The Division of Corporations and Commercial Code shall file both the certificate

4268 of organization and the certificate described in Subsection (7) for a captive insurance company
4269 that complies with this section.

4270 (10) (a) The organizers of a captive insurance company formed as a reciprocal insurer
4271 shall obtain from the commissioner a certificate finding that the establishment and maintenance
4272 of the proposed association will promote the general good of the state.

4273 (b) In considering a request for a certificate under Subsection (10)(a), the
4274 commissioner shall consider:

4275 (i) the character, reputation, financial standing, and purposes of the incorporators;

4276 (ii) the character, reputation, financial responsibility, insurance experience, and
4277 business qualifications of the officers and directors;

4278 (iii) any information in:

4279 (A) the application for a certificate of authority; or

4280 (B) the department's files; and

4281 (iv) other aspects that the commissioner considers advisable.

4282 (11) (a) An alien captive insurance company that has received a certificate of authority
4283 to act as a branch captive insurance company shall obtain from the commissioner a certificate
4284 finding that:

4285 (i) the home ~~[state]~~ jurisdiction of the alien captive insurance company imposes
4286 statutory or regulatory standards in a form acceptable to the commissioner on companies
4287 transacting the business of insurance in that state; and

4288 (ii) after considering the character, reputation, financial responsibility, insurance
4289 experience, and business qualifications of the officers and directors of the alien captive
4290 insurance company, and other relevant information, the establishment and maintenance of the
4291 branch operations will promote the general good of the state.

4292 (b) After the commissioner issues a certificate under Subsection (11)(a) to an alien
4293 captive insurance company, the alien captive insurance company may register to do business in
4294 this state.

4295 (12) At least one of the members of the board of directors of a captive insurance
4296 company formed as a corporation shall be a resident of this state.

4297 (13) At least one of the managers of a limited liability company shall be a resident of
4298 this state.

4299 ~~[(14) At least one of the members of the subscribers' advisory committee of a captive~~
4300 ~~insurance company formed as a reciprocal insurer shall be a resident of this state.]~~

4301 ~~[(15)]~~ (14) (a) A captive insurance company formed as a corporation under this chapter
4302 has the privileges and is subject to the provisions of the general corporation law as well as the
4303 applicable provisions contained in this chapter.

4304 (b) If a conflict exists between a provision of the general corporation law and a
4305 provision of this chapter, this chapter shall control.

4306 (c) Except as provided in Subsection ~~[(15)]~~ (14)(d), the provisions of this title
4307 pertaining to a merger, consolidation, conversion, mutualization, and redomestication apply in
4308 determining the procedures to be followed by a captive insurance company in carrying out any
4309 of the transactions described in those provisions.

4310 (d) Notwithstanding Subsection ~~[(15)]~~ (14)(c), the commissioner may waive or modify
4311 the requirements for public notice and hearing in accordance with rules adopted under Section
4312 [31A-37-106](#).

4313 (e) If a notice of public hearing is required, but no one requests a hearing, the
4314 commissioner may cancel the public hearing.

4315 ~~[(16)]~~ (15) (a) A captive insurance company formed as a limited liability company
4316 under this chapter has the privileges and is subject to ~~[Title 48, Chapter 2c, Utah Revised~~
4317 ~~Limited Liability Company Act, or]~~ Title 48, Chapter 3a, Utah Revised Uniform Limited
4318 Liability Company Act~~[, as appropriate pursuant to Section [48-3a-1405](#)],~~ as well as the
4319 applicable provisions in this chapter.

4320 (b) If a conflict exists between a provision of the limited liability company law and a
4321 provision of this chapter, this chapter controls.

4322 (c) The provisions of this title pertaining to a merger, consolidation, conversion,
4323 mutualization, and redomestication apply in determining the procedures to be followed by a
4324 captive insurance company in carrying out any of the transactions described in those
4325 provisions.

4326 (d) Notwithstanding Subsection ~~[(16)]~~ (15)(c), the commissioner may waive or modify
4327 the requirements for public notice and hearing in accordance with rules adopted under Section
4328 31A-37-106.

4329 (e) If a notice of public hearing is required, but no one requests a hearing, the
4330 commissioner may cancel the public hearing.

4331 ~~[(17) (a) A captive insurance company formed as a reciprocal insurer under this chapter
4332 has the powers set forth in Section 31A-4-114 in addition to the applicable provisions of this
4333 chapter.]~~

4334 ~~[(b) If a conflict exists between the provisions of Section 31A-4-114 and the provisions
4335 of this chapter with respect to a captive insurance company, this chapter shall control.]~~

4336 ~~[(c) To the extent a reciprocal insurer is made subject to other provisions of this title
4337 pursuant to Section 31A-14-208, the provisions are not applicable to a reciprocal insurer
4338 formed under this chapter unless the provisions are expressly made applicable to a captive
4339 insurance company under this chapter.]~~

4340 ~~[(d) In addition to the provisions of this Subsection (17), a captive insurance company
4341 organized as a reciprocal insurer that is an industrial insured group has the privileges of Section
4342 31A-4-114 in addition to applicable provisions of this title.]~~

4343 ~~[(18)]~~ (16) (a) The articles of incorporation or bylaws of a captive insurance company
4344 formed as a corporation may not authorize a quorum of a board of directors to consist of fewer
4345 than one-third of the fixed or prescribed number of directors as provided in Section
4346 16-10a-824.

4347 (b) The certificate of organization of a captive insurance company formed as a limited
4348 liability company may not authorize a quorum of a board of managers to consist of fewer than

4349 one-third of the fixed or prescribed number of directors required in Section 16-10a-824.

4350 Section 63. Section 31A-37-303 is amended to read:

4351 **31A-37-303. Reinsurance.**

4352 (1) A captive insurance company may cede risks to any insurance company approved
4353 by the commissioner. A captive insurance company may provide reinsurance, as authorized in
4354 this title, on risks ceded for the benefit of a parent, affiliate, or controlled unaffiliated business.

4355 (2) (a) A captive insurance company may take credit for reserves on risks or portions of
4356 risks ceded to reinsurers if the captive insurance company complies with Section 31A-17-404,
4357 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or if the captive insurance company complies
4358 with other requirements as the commissioner may establish by rule made in accordance with
4359 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4360 (b) Unless the reinsurer is in compliance with Section 31A-17-404, 31A-17-404.1,
4361 31A-17-404.3, or 31A-17-404.4 or a rule adopted under Subsection (2)(a), a captive insurance
4362 company may not take credit for:

- 4363 (i) reserves on risks ceded to a reinsurer; or
- 4364 (ii) portions of risks ceded to a reinsurer.

4365 Section 64. Section 31A-37-305 is amended to read:

4366 **31A-37-305. Contributions to guaranty or insolvency fund prohibited.**

4367 (1) A captive insurance company[~~, including a captive insurance company organized as~~
4368 ~~a reciprocal insurer under this chapter,~~] may not join or contribute financially to any of the
4369 following in this state:

- 4370 (a) a plan;
- 4371 (b) a pool;
- 4372 (c) an association;
- 4373 (d) a guaranty fund; or
- 4374 (e) an insolvency fund.

4375 (2) A captive insurance company, the insured of a captive insurance company, the

4376 parent of a captive insurance company, an affiliate of a captive insurance company, or a
 4377 member organization of an association captive insurance company~~], or in the case of a captive~~
 4378 ~~insurance company organized as a reciprocal insurer, a subscriber of the captive insurance~~
 4379 ~~company,]~~ may not receive a benefit from:

- 4380 (a) a plan;
- 4381 (b) a pool;
- 4382 (c) an association;
- 4383 (d) a guaranty fund for claims arising out of the operations of the captive insurance
 4384 company; or
- 4385 (e) an insolvency fund for claims arising out of the operations of the captive insurance
 4386 company.

4387 Section 65. Section **31A-42-201** is amended to read:

4388 **31A-42-201. Creation of risk adjuster mechanism -- Board of directors --**
 4389 **Appointment -- Terms -- Quorum -- Plan preparation.**

4390 (1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity
 4391 within the department.

4392 (2) (a) The risk adjuster is under the direction of a board of directors composed of up to
 4393 nine members described in Subsection (2)(b).

4394 (b) The board of directors shall consist of:

4395 (i) the following directors appointed by the governor with the consent of the Senate:

4396 (A) at least ~~[three]~~ one, but up to five, directors with actuarial experience who
 4397 represent insurers~~[-(f)]~~ that are participating or have committed to participate in the defined
 4398 contribution arrangement market in the state; ~~[and]~~

4399 ~~[(H) including at least one and up to two directors who represent an insurer that has a~~
 4400 ~~small percentage of lives in the defined contribution market;]~~

4401 (B) one director who represents either an individual employee or employer; and

4402 (C) one director who represents the Office of Consumer Health Services within the

4403 Governor's Office of Economic Development;

4404 (ii) one director representing the Public Employees' Benefit and Insurance Program
4405 with actuarial experience, appointed by the director of the Public Employees' Benefit and
4406 Insurance Program; and

4407 (iii) the commissioner, or a representative of the commissioner who:

4408 (A) is appointed by the commissioner; and

4409 (B) has actuarial experience.

4410 (c) The commissioner, or a representative appointed by the commissioner may vote
4411 only in the event of a tie vote.

4412 (3) (a) Except as required by Subsection (3)(b), as terms of current board members
4413 appointed by the governor expire, the governor shall appoint each new member or reappointed
4414 member to a four-year term.

4415 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the
4416 time of appointment or reappointment, adjust the length of terms to ensure that the terms of
4417 board members are staggered so that approximately half of the board is appointed every two
4418 years.

4419 (c) Notwithstanding the requirements of Subsection (3)(a), a board member shall
4420 continue to serve until the board member is reappointed or replaced by another individual in
4421 accordance with this section.

4422 (4) When a vacancy occurs in the membership for any reason, the replacement shall be
4423 appointed for the unexpired term in the same manner as the original appointment was made.

4424 (5) (a) A board member who is not a government employee may not receive
4425 compensation or benefits for the board member's services.

4426 (b) A state government member who is a board member because of the board member's
4427 state government position may not receive per diem or expenses for the member's service.

4428 (6) The board shall elect annually a chair and vice chair from its membership.

4429 (7) A majority of the board members is a quorum for the transaction of business.

4430 (8) The action of a majority of the members of the quorum is the action of the board.

4431 Section 66. Section **31A-44-603** is amended to read:

4432 **31A-44-603. Examinations.**

4433 (1) The department may conduct periodic on-site examinations of a provider.

4434 (2) In conducting an examination, the department or the department's staff:

4435 (a) shall have full and free access to all the provider's records; and

4436 (b) may summon and qualify as a witness, under oath, and examine, any director,
4437 officer, member, agent, or employee of the provider, and any other person, concerning the
4438 condition and affairs of the provider or a facility.

4439 (3) Books and records shall be kept for not less than three calendar years in addition to
4440 the current calendar year.

4441 [~~3~~] (4) The provider shall pay the reasonable costs of an examination under this
4442 section.

4443 [~~4~~] (5) The department may conduct an on-site examination in conjunction with an
4444 examination performed by a representative of an agency of another state.

4445 [~~5~~] (6) (a) The department, in lieu of an on-site examination, may accept the
4446 examination report of an agency of another state that has regulatory oversight of the provider,
4447 or a report prepared by an independent accounting firm.

4448 (b) A report accepted under Subsection [~~5~~] (6)(a) is considered for all purposes an
4449 official report of the department.

4450 [~~6~~] (7) Upon reasonable cause, the department may conduct an on-site examination of
4451 an unlicensed person to determine whether a violation of this chapter has occurred.

4452 Section 67. Section **53-2a-1102** is amended to read:

4453 **53-2a-1102. Search and Rescue Financial Assistance Program -- Uses --**
4454 **Rulemaking -- Distribution.**

4455 (1) (a) "Assistance card program" means the Utah Search and Rescue Assistance Card
4456 Program created within this section.

4457 (b) "Card" means the Search and Rescue Assistance Card issued under this section to a
4458 participant.

4459 (c) "Participant" means an individual, family, or group who is registered pursuant to
4460 this section as having a valid card at the time search, rescue, or both are provided.

4461 (d) "Program" means the Search and Rescue Financial Assistance Program created
4462 within this section.

4463 (e) (i) "Reimbursable expenses," as used in this section, means those reasonable
4464 expenses incidental to search and rescue activities.

4465 (ii) "Reimbursable expenses" include:

4466 (A) rental for fixed wing aircraft, helicopters, snowmobiles, boats, and generators;

4467 (B) replacement and upgrade of search and rescue equipment;

4468 (C) training of search and rescue volunteers;

4469 (D) costs of providing workers' compensation benefits for volunteer search and rescue
4470 team members under Section 67-20-7.5; and

4471 (E) any other equipment or expenses necessary or appropriate for conducting search
4472 and rescue activities.

4473 (iii) "Reimbursable expenses" do not include any salary or overtime paid to any person
4474 on a regular or permanent payroll, including permanent part-time employees of any agency of
4475 the state.

4476 (f) "Rescue" means search services, rescue services, or both search and rescue services.

4477 (2) There is created the Search and Rescue Financial Assistance Program within the
4478 division.

4479 (3) (a) The program shall be funded from the following revenue sources:

4480 (i) any voluntary contributions to the state received for search and rescue operations;

4481 (ii) money received by the state under Subsection (11) and under Sections 23-19-42,
4482 41-22-34, and 73-18-24; and

4483 (iii) appropriations made to the program by the Legislature.

4484 (b) All money received from the revenue sources in Subsections (3)(a)(i) and (ii) shall
4485 be deposited into the General Fund as a dedicated credit to be used solely for the purposes
4486 under this section.

4487 (c) All funding for the program is nonlapsing.

4488 (4) The director shall use the money to reimburse counties for all or a portion of each
4489 county's reimbursable expenses for search and rescue operations, subject to:

4490 (a) the approval of the Search and Rescue Advisory Board as provided in Section
4491 [53-2a-1104](#);

4492 (b) money available in the program; and

4493 (c) rules made under Subsection (7).

4494 (5) Program money may not be used to reimburse for any paid personnel costs or paid
4495 man hours spent in emergency response and search and rescue related activities.

4496 (6) The Legislature finds that these funds are for a general and statewide public
4497 purpose.

4498 (7) The division, with the approval of the Search and Rescue Advisory Board, shall
4499 make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and
4500 consistent with this section:

4501 (a) specifying the costs that qualify as reimbursable expenses;

4502 (b) defining the procedures of counties to submit expenses and be reimbursed;

4503 (c) defining a participant in the assistance card program, including:

4504 (i) individuals; and

4505 (ii) families and organized groups who qualify as participants;

4506 (d) defining the procedure for issuing a card to a participant;

4507 (e) defining excluded expenses that may not be reimbursed under the program,
4508 including medical expenses;

4509 (f) establishing the card renewal cycle for the Utah Search and Rescue Assistance Card
4510 Program;

- 4511 (g) establishing the frequency of review of the fee schedule;
- 4512 (h) providing for the administration of the program; and
- 4513 (i) providing a formula to govern the distribution of available money among the
- 4514 counties for uncompensated search and rescue expenses based on:
 - 4515 (i) the total qualifying expenses submitted;
 - 4516 (ii) the number of search and rescue incidents per county population;
 - 4517 (iii) the number of victims that reside outside the county; and
 - 4518 (iv) the number of volunteer hours spent in each county in emergency response and
 - 4519 search and rescue related activities per county population.

4520 (8) (a) The division shall, in consultation with the Outdoor Recreation Office, establish

4521 the fee schedule of the Search and Rescue Assistance Card under Subsection 63J-1-504(6).

4522 (b) The division shall provide a discount of not less than 10% of the card fee under

4523 Subsection (8)(a) to a person who has paid a fee under Section 23-19-42, 41-22-34, or

4524 73-18-24 during the same calendar year in which the person applies to be a participant in the

4525 assistance card program.

4526 (9) (a) Counties may bill reimbursable expenses to an individual for costs incurred for

4527 the rescue of an individual, if the individual is not a participant in the Utah Search and Rescue

4528 Assistance Card Program.

4529 (b) Counties may bill a participant for reimbursable expenses for costs incurred for the

4530 rescue of the participant if the participant is found by the rescuing county to have acted

4531 recklessly or to have intentionally created a situation resulting in the need for a county to

4532 provide rescue service for the participant.

4533 (10) (a) There is created the Utah Search and Rescue Assistance Card Program. The

4534 program is located within the division.

4535 (b) The program may not be utilized to cover any expenses, such as medically related

4536 expenses, that are not reimbursable expenses related to the rescue.

4537 (11) (a) To participate in the program, a person shall purchase a Search and Rescue

4538 Assistance Card from the division by paying the fee as determined by the division in
4539 Subsection (8).

4540 (b) The money generated by the fees shall be deposited into the General Fund as a
4541 dedicated credit for the Search and Rescue Financial Assistance Program created in this
4542 section.

4543 (c) Participation and payment of fees by a person under Sections 23-19-42, 41-22-34,
4544 and 73-18-24 do not constitute purchase of a card under this section.

4545 (12) The division shall consult with the Outdoor Recreation Office regarding:

4546 (a) administration of the assistance card program; and

4547 (b) outreach and marketing strategies.

4548 (13) Pursuant to Subsection 31A-1-103(7), the Utah Search and Rescue Assistance
4549 Card Program under this section is exempt from being considered ~~[an]~~ insurance ~~[program~~
4550 ~~under Subsection]~~ as defined in Section 31A-1-301~~[(86)]~~.

4551 Section 68. Section 59-7-102 is amended to read:

4552 **59-7-102. Exemptions.**

4553 (1) Except as provided in this section, the following are exempt from a tax under this
4554 chapter:

4555 (a) an organization exempt under Section 501, Internal Revenue Code;

4556 (b) an organization exempt under Section 528, Internal Revenue Code;

4557 (c) an insurance company that is subject to taxation on the insurance company's
4558 premiums under Chapter 9, Taxation of Admitted Insurers, regardless of whether the insurance
4559 company has a tax liability under that chapter;

4560 (d) a local building authority as defined in Section 17D-2-102;

4561 (e) a farmers' cooperative; ~~[or]~~

4562 (f) a public agency, as defined in Section 11-13-103, with respect to or as a result of an
4563 ownership interest in:

4564 (i) a project, as defined in Section 11-13-103; or

- 4565 (ii) facilities providing additional project capacity, as defined in Section [11-13-103](#)[-];
- 4566 (g) an insurance company that engages in a transaction that is subject to taxation under
- 4567 Section [31A-3-301](#) or [31A-3-302](#), regardless of whether the insurance company has a tax
- 4568 liability under that section; or
- 4569 (h) a captive insurance company that pays a fee under Section [31A-3-304](#).
- 4570 (2) A corporation is exempt from a tax under this chapter:
- 4571 (a) if the corporation is an out-of-state business as defined in Section [53-2a-1202](#); and
- 4572 (b) for income earned:
- 4573 (i) during a disaster period as defined in Section [53-2a-1202](#); and
- 4574 (ii) for the purpose of responding to a declared state disaster or emergency as defined
- 4575 in Section [53-2a-1202](#).
- 4576 (3) Notwithstanding any other provision in this chapter or Chapter 8, Gross Receipts
- 4577 Tax on Certain Corporations Not Required to Pay Corporate Franchise or Income Tax Act, a
- 4578 person not otherwise subject to the tax imposed by this chapter or Chapter 8, Gross Receipts
- 4579 Tax on Certain Corporations Not Required to Pay Corporate Franchise or Income Tax Act, is
- 4580 not subject to a tax imposed by Section [59-7-104](#), [59-7-201](#), [59-7-701](#), or [59-8-104](#), because of:
- 4581 (a) that person's ownership of tangible personal property located at the premises of a
- 4582 printer's facility in this state with which the person has contracted for printing; or
- 4583 (b) the activities of the person's employees or agents who are:
- 4584 (i) located solely at the premises of a printer's facility; and
- 4585 (ii) performing services:
- 4586 (A) related to:
- 4587 (I) quality control;
- 4588 (II) distribution; or
- 4589 (III) printing services; and
- 4590 (B) performed by the printer's facility in this state with which the person has contracted
- 4591 for printing.

4592 (4) Notwithstanding Subsection (1), an organization, company, authority, farmers'
 4593 cooperative, or public agency exempt from this chapter under Subsection (1) is subject to Part
 4594 8, Unrelated Business Income, to the extent provided in Part 8, Unrelated Business Income.

4595 (5) Notwithstanding Subsection (1)(b), to the extent the income of an organization
 4596 described in Subsection (1)(b) is taxable for federal tax purposes under Section 528, Internal
 4597 Revenue Code, the organization's income is also taxable under this chapter.

4598 Section 69. Section **59-9-101** is amended to read:

4599 **59-9-101. Tax basis -- Rates -- Exemptions -- Rate reductions.**

4600 (1) (a) Except as provided in Subsection (1)(b), (1)(d), or (5), an admitted insurer shall
 4601 pay to the commission on or before March 31 in each year, a tax of 2-1/4% of the total
 4602 premiums received by it during the preceding calendar year from insurance covering property
 4603 or risks located in this state.

4604 (b) This Subsection (1) does not apply to:

4605 (i) workers' compensation insurance, assessed under Subsection (2);

4606 (ii) title insurance premiums taxed under Subsection (3);

4607 (iii) annuity considerations;

4608 (iv) insurance premiums paid by an institution within the state system of higher
 4609 education as specified in Section [53B-1-102](#); and

4610 (v) ocean marine insurance.

4611 (c) The taxable premium under this Subsection (1) shall be reduced by:

4612 (i) the premiums returned or credited to policyholders on direct business subject to tax
 4613 in this state;

4614 (ii) the premiums received for reinsurance of property or risks located in this state; and

4615 (iii) the dividends, including premium reduction benefits maturing within the year:

4616 (A) paid or credited to policyholders in this state; or

4617 (B) applied in abatement or reduction of premiums due during the preceding calendar
 4618 year.

4619 (d) (i) For purposes of this Subsection (1)(d):
4620 (A) "Utah variable life insurance premium" means an insurance premium paid:
4621 (I) by:
4622 (Aa) a corporation; or
4623 (Bb) a trust established or funded by a corporation; and
4624 (II) for variable life insurance covering risks located within the state.
4625 (B) "Variable life insurance" means an insurance policy that provides for life
4626 insurance, the amount or duration of which varies according to the investment experience of
4627 one or more separate accounts that are established and maintained by the insurer pursuant to
4628 Title 31A, Insurance Code.

4629 (ii) Notwithstanding Subsection (1)(a), beginning on January 1, 2006, the tax on that
4630 portion of the total premiums subject to a tax under Subsection (1)(a) that is a Utah variable
4631 life insurance premium shall be calculated as follows:

4632 (A) 2-1/4% of the first \$100,000 of Utah variable life insurance premiums:

4633 (I) paid for each variable life insurance policy; and

4634 (II) received by the admitted insurer in the preceding calendar year; and

4635 (B) 0.08% of the Utah variable life insurance premiums that exceed \$100,000:

4636 (I) paid for the policy described in Subsection (1)(d)(ii)(A); and

4637 (II) received by the admitted insurer in the preceding calendar year.

4638 (2) (a) An admitted insurer writing workers' compensation insurance in this state,
4639 including the Workers' Compensation Fund created under Title 31A, Chapter 33, Workers'
4640 Compensation Fund, shall pay to the tax commission, on or before March 31 in each year, a
4641 premium assessment on the basis of the total workers' compensation premium income received
4642 by the insurer from workers' compensation insurance in this state during the preceding calendar
4643 year as follows:

4644 (i) on or before December 31, 2010, an amount of equal to or greater than 1%, but
4645 equal to or less than 5.75% of the total workers' compensation premium income described in

4646 this Subsection (2);

4647 (ii) on and after January 1, 2011, but on or before December 31, 2017, an amount of
4648 equal to or greater than 1%, but equal to or less than 4.25% of the total workers' compensation
4649 premium income described in this Subsection (2); and

4650 (iii) on and after January 1, 2018, an amount equal to 1.25% of the total workers'
4651 compensation premium income described in this Subsection (2).

4652 (b) Total workers' compensation premium income means the net written premium as
4653 calculated before any premium reduction for any insured employer's deductible, retention, or
4654 reimbursement amounts and also those amounts equivalent to premiums as provided in Section
4655 [34A-2-202](#).

4656 (c) The percentage of premium assessment applicable for a calendar year shall be
4657 determined by the Labor Commission under Subsection (2)(d). The total premium income
4658 shall be reduced in the same manner as provided in Subsections (1)(c)(i) and (1)(c)(ii), but not
4659 as provided in Subsection (1)(c)(iii). The commission shall promptly remit from the premium
4660 assessment collected under this Subsection (2):

4661 (i) income to the state treasurer for credit to the Employers' Reinsurance Fund created
4662 under Subsection [34A-2-702](#)(1) as follows:

4663 (A) on or before December 31, 2009, an amount of up to 5% of the total workers'
4664 compensation premium income;

4665 (B) on and after January 1, 2010, but on or before December 31, 2010, an amount of up
4666 to 4.5% of the total workers' compensation premium income;

4667 (C) on and after January 1, 2011, but on or before December 31, 2017, an amount of up
4668 to 3% of the total workers' compensation premium income; and

4669 (D) on and after January 1, 2018, 0% of the total workers' compensation premium
4670 income;

4671 (ii) an amount equal to 0.25% of the total workers' compensation premium income to
4672 the state treasurer for credit to the Workplace Safety Account created by Section [34A-2-701](#);

4673 (iii) an amount of up to 0.5% and any remaining assessed percentage of the total
4674 workers' compensation premium income to the state treasurer for credit to the Uninsured
4675 Employers' Fund created under Section 34A-2-704; and

4676 (iv) beginning on January 1, 2010, 0.5% of the total workers' compensation premium
4677 income to the state treasurer for credit to the Industrial Accident Restricted Account created in
4678 Section 34A-2-705.

4679 (d) (i) The Labor Commission shall determine the amount of the premium assessment
4680 for each year on or before each October 15 of the preceding year. The Labor Commission shall
4681 make this determination following a public hearing. The determination shall be based upon the
4682 recommendations of a qualified actuary.

4683 (ii) The actuary shall recommend a premium assessment rate sufficient to provide
4684 payments of benefits and expenses from the Employers' Reinsurance Fund and to project a
4685 funded condition with assets greater than liabilities by no later than June 30, 2025.

4686 (iii) The actuary shall recommend a premium assessment rate sufficient to provide
4687 payments of benefits and expenses from the Uninsured Employers' Fund and to maintain it at a
4688 funded condition with assets equal to or greater than liabilities.

4689 (iv) At the end of each fiscal year the minimum approximate assets in the Employers'
4690 Reinsurance Fund shall be \$5,000,000 which amount shall be adjusted each year beginning in
4691 1990 by multiplying by the ratio that the total workers' compensation premium income for the
4692 preceding calendar year bears to the total workers' compensation premium income for the
4693 calendar year 1988.

4694 (v) The requirements of Subsection (2)(d)(iv) cease when the future annual
4695 disbursements from the Employers' Reinsurance Fund are projected to be less than the
4696 calculations of the corresponding future minimum required assets. The Labor Commission
4697 shall, after a public hearing, determine if the future annual disbursements are less than the
4698 corresponding future minimum required assets from projections provided by the actuary.

4699 (vi) At the end of each fiscal year the minimum approximate assets in the Uninsured

4700 Employers' Fund shall be \$2,000,000, which amount shall be adjusted each year beginning in
4701 1990 by multiplying by the ratio that the total workers' compensation premium income for the
4702 preceding calendar year bears to the total workers' compensation premium income for the
4703 calendar year 1988.

4704 (e) A premium assessment that is to be transferred into the General Fund may be
4705 collected on premiums received from Utah public agencies.

4706 (3) An admitted insurer writing title insurance in this state shall pay to the commission,
4707 on or before March 31 in each year, a tax of .45% of the total premium received by either the
4708 insurer or by its agents during the preceding calendar year from title insurance concerning
4709 property located in this state. In calculating this tax, "premium" includes the charges made to
4710 an insured under or to an applicant for a policy or contract of title insurance for:

4711 (a) the assumption by the title insurer of the risks assumed by the issuance of the policy
4712 or contract of title insurance; and

4713 (b) abstracting title, title searching, examining title, or determining the insurability of
4714 title, and every other activity, exclusive of escrow, settlement, or closing charges, whether
4715 denominated premium or otherwise, made by a title insurer, an agent of a title insurer, a title
4716 insurance producer, or any of them.

4717 (4) Beginning July 1, 1986, a former county mutual and a former mutual benefit
4718 association shall pay the premium tax or assessment due under this chapter. Premiums
4719 received after July 1, 1986, shall be considered in determining the tax or assessment.

4720 (5) The following insurers are not subject to the premium tax on health care insurance
4721 that would otherwise be applicable under Subsection (1):

4722 (a) an insurer licensed under Title 31A, Chapter 5, Domestic Stock and Mutual
4723 Insurance Corporations;

4724 (b) an insurer licensed under Title 31A, Chapter 7, Nonprofit Health Service Insurance
4725 Corporations;

4726 (c) an insurer licensed under Title 31A, Chapter 8, Health Maintenance Organizations

4727 and Limited Health Plans;

4728 (d) an insurer licensed under Title 31A, Chapter 9, Insurance Fraternal;

4729 (e) an insurer licensed under Title 31A, Chapter 11, Motor Clubs;

4730 (f) an insurer licensed under Title 31A, Chapter 13, Employee Welfare Funds and

4731 Plans; and

4732 (g) an insurer licensed under Title 31A, Chapter 14, Foreign Insurers.

4733 (6) A captive insurer, as provided in Section 31A-3-304, that pays a fee imposed under

4734 Section 31A-3-304 is not subject to the premium tax under this section.

4735 ~~[(6)]~~ (7) An insurer issuing multiple policies to an insured may not artificially allocate

4736 the premiums among the policies for purposes of reducing the aggregate premium tax or

4737 assessment applicable to the policies.

4738 ~~[(7)]~~ (8) The retaliatory provisions of Title 31A, Chapter 3, Department Funding, Fees,

4739 and Taxes, apply to the tax or assessment imposed under this chapter.

4740 Section 70. Section 63G-2-302 is amended to read:

4741 **63G-2-302. Private records.**

4742 (1) The following records are private:

4743 (a) records concerning an individual's eligibility for unemployment insurance benefits,
4744 social services, welfare benefits, or the determination of benefit levels;

4745 (b) records containing data on individuals describing medical history, diagnosis,
4746 condition, treatment, evaluation, or similar medical data;

4747 (c) records of publicly funded libraries that when examined alone or with other records
4748 identify a patron;

4749 (d) records received by or generated by or for:

4750 (i) the Independent Legislative Ethics Commission, except for:

4751 (A) the commission's summary data report that is required under legislative rule; and

4752 (B) any other document that is classified as public under legislative rule; or

4753 (ii) a Senate or House Ethics Committee in relation to the review of ethics complaints,

- 4754 unless the record is classified as public under legislative rule;
- 4755 (e) records received by, or generated by or for, the Independent Executive Branch
- 4756 Ethics Commission, except as otherwise expressly provided in Title 63A, Chapter 14, Review
- 4757 of Executive Branch Ethics Complaints;
- 4758 (f) records received or generated for a Senate confirmation committee concerning
- 4759 character, professional competence, or physical or mental health of an individual:
- 4760 (i) if, prior to the meeting, the chair of the committee determines release of the records:
- 4761 (A) reasonably could be expected to interfere with the investigation undertaken by the
- 4762 committee; or
- 4763 (B) would create a danger of depriving a person of a right to a fair proceeding or
- 4764 impartial hearing; and
- 4765 (ii) after the meeting, if the meeting was closed to the public;
- 4766 (g) employment records concerning a current or former employee of, or applicant for
- 4767 employment with, a governmental entity that would disclose that individual's home address,
- 4768 home telephone number, social security number, insurance coverage, marital status, or payroll
- 4769 deductions;
- 4770 (h) records or parts of records under Section [63G-2-303](#) that a current or former
- 4771 employee identifies as private according to the requirements of that section;
- 4772 (i) that part of a record indicating a person's social security number or federal employer
- 4773 identification number if provided under Section [31A-23a-104](#), [31A-25-202](#), [31A-26-202](#),
- 4774 [58-1-301](#), [58-55-302](#), [61-1-4](#), or [61-2f-203](#);
- 4775 (j) that part of a voter registration record identifying a voter's:
- 4776 (i) driver license or identification card number;
- 4777 (ii) Social Security number, or last four digits of the Social Security number;
- 4778 (iii) email address; or
- 4779 (iv) date of birth;
- 4780 (k) a voter registration record that is classified as a private record by the lieutenant

4781 governor or a county clerk under Subsection 20A-2-104(4)(f) or 20A-2-101.1(5)(a);
4782 (l) a record that:
4783 (i) contains information about an individual;
4784 (ii) is voluntarily provided by the individual; and
4785 (iii) goes into an electronic database that:
4786 (A) is designated by and administered under the authority of the Chief Information
4787 Officer; and
4788 (B) acts as a repository of information about the individual that can be electronically
4789 retrieved and used to facilitate the individual's online interaction with a state agency;
4790 (m) information provided to the Commissioner of Insurance under:
4791 (i) Subsection 31A-23a-115~~(2)~~(3)(a);
4792 (ii) Subsection 31A-23a-302~~(3)~~(4); or
4793 (iii) Subsection 31A-26-210~~(3)~~(4);
4794 (n) information obtained through a criminal background check under Title 11, Chapter
4795 40, Criminal Background Checks by Political Subdivisions Operating Water Systems;
4796 (o) information provided by an offender that is:
4797 (i) required by the registration requirements of Title 77, Chapter 41, Sex and Kidnap
4798 Offender Registry; and
4799 (ii) not required to be made available to the public under Subsection 77-41-110(4);
4800 (p) a statement and any supporting documentation filed with the attorney general in
4801 accordance with Section 34-45-107, if the federal law or action supporting the filing involves
4802 homeland security;
4803 (q) electronic toll collection customer account information received or collected under
4804 Section 72-6-118 and customer information described in Section 17B-2a-815 received or
4805 collected by a public transit district, including contact and payment information and customer
4806 travel data;
4807 (r) an email address provided by a military or overseas voter under Section

4808 20A-16-501;

4809 (s) a completed military-overseas ballot that is electronically transmitted under Title
4810 20A, Chapter 16, Uniform Military and Overseas Voters Act;

4811 (t) records received by or generated by or for the Political Subdivisions Ethics Review
4812 Commission established in Section 11-49-201, except for:

4813 (i) the commission's summary data report that is required in Section 11-49-202; and

4814 (ii) any other document that is classified as public in accordance with Title 11, Chapter
4815 49, Political Subdivisions Ethics Review Commission;

4816 (u) a record described in Subsection 53A-11a-203(3) that verifies that a parent was
4817 notified of an incident or threat; and

4818 (v) a criminal background check or credit history report conducted in accordance with
4819 Section 63A-3-201.

4820 (2) The following records are private if properly classified by a governmental entity:

4821 (a) records concerning a current or former employee of, or applicant for employment
4822 with a governmental entity, including performance evaluations and personal status information
4823 such as race, religion, or disabilities, but not including records that are public under Subsection
4824 63G-2-301(2)(b) or 63G-2-301(3)(o) or private under Subsection (1)(b);

4825 (b) records describing an individual's finances, except that the following are public:

4826 (i) records described in Subsection 63G-2-301(2);

4827 (ii) information provided to the governmental entity for the purpose of complying with
4828 a financial assurance requirement; or

4829 (iii) records that must be disclosed in accordance with another statute;

4830 (c) records of independent state agencies if the disclosure of those records would
4831 conflict with the fiduciary obligations of the agency;

4832 (d) other records containing data on individuals the disclosure of which constitutes a
4833 clearly unwarranted invasion of personal privacy;

4834 (e) records provided by the United States or by a government entity outside the state

4835 that are given with the requirement that the records be managed as private records, if the
4836 providing entity states in writing that the record would not be subject to public disclosure if
4837 retained by it;

4838 (f) any portion of a record in the custody of the Division of Aging and Adult Services,
4839 created in Section 62A-3-102, that may disclose, or lead to the discovery of, the identity of a
4840 person who made a report of alleged abuse, neglect, or exploitation of a vulnerable adult; and

4841 (g) audio and video recordings created by a body-worn camera, as defined in Section
4842 77-7a-103, that record sound or images inside a home or residence except for recordings that:

4843 (i) depict the commission of an alleged crime;

4844 (ii) record any encounter between a law enforcement officer and a person that results in
4845 death or bodily injury, or includes an instance when an officer fires a weapon;

4846 (iii) record any encounter that is the subject of a complaint or a legal proceeding
4847 against a law enforcement officer or law enforcement agency;

4848 (iv) contain an officer involved critical incident as defined in Section 76-2-408(1)(d);

4849 or

4850 (v) have been requested for reclassification as a public record by a subject or
4851 authorized agent of a subject featured in the recording.

4852 (3) (a) As used in this Subsection (3), "medical records" means medical reports,
4853 records, statements, history, diagnosis, condition, treatment, and evaluation.

4854 (b) Medical records in the possession of the University of Utah Hospital, its clinics,
4855 doctors, or affiliated entities are not private records or controlled records under Section
4856 63G-2-304 when the records are sought:

4857 (i) in connection with any legal or administrative proceeding in which the patient's
4858 physical, mental, or emotional condition is an element of any claim or defense; or

4859 (ii) after a patient's death, in any legal or administrative proceeding in which any party
4860 relies upon the condition as an element of the claim or defense.

4861 (c) Medical records are subject to production in a legal or administrative proceeding

4862 according to state or federal statutes or rules of procedure and evidence as if the medical
4863 records were in the possession of a nongovernmental medical care provider.

4864 Section 71. **Repealer.**

4865 This bill repeals:

4866 Section [31A-22-715](#), **Alcohol and drug dependency treatment.**

4867 Section [31A-22-718](#), **Dependent coverage.**

4868 Section [31A-34-101](#), **Title.**

4869 Section [31A-34-102](#), **Purpose and intent -- Legislative findings.**

4870 Section [31A-34-103](#), **Definitions.**

4871 Section [31A-34-104](#), **Alliance -- Required license.**

4872 Section [31A-34-105](#), **Association requirements.**

4873 Section [31A-34-106](#), **Jurisdiction of the commissioner.**

4874 Section [31A-34-107](#), **Directors, trustees, and officers.**

4875 Section [31A-34-108](#), **Powers of and restrictions on alliances.**

4876 Section [31A-34-109](#), **Operation of alliances.**

4877 Section [31A-34-110](#), **Contracts with member employers and contracted insurers.**

4878 Section [31A-34-111](#), **Alliance evaluation.**

4879 Section [31A-37-306](#), **Conversion or merger.**

4880 Section 72. **Retrospective operation.**

4881 (1) The amendments in this bill to Section [31A-3-102](#) and Section [59-7-102](#) have
4882 retrospective operation for a taxable year beginning on or after January 1, 2017.

4883 (2) The amendments in this bill to Section [59-9-101](#) have retrospective operation to
4884 January 1, 2017.