1 # UTAH LIFE AND HEALTH INSURANCE GUARANTY
2 # ASSOCIATION AMENDMENTS

3 2018 GENERAL SESSION
4 STATE OF UTAH
5 **Chief Sponsor: James A. Dunnigan**
6 Senate Sponsor: Curtis S. Bramble

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8 **LONG TITLE**
9 **General Description:**
10 This bill amends provisions relating to the Utah Life and Health Insurance Guaranty
11 Association.
12 **Highlighted Provisions:**
13 This bill:
14 ▸ extends guaranty association membership and coverage to health maintenance
15 organizations;
16 ▸ excludes structured settlement factoring transactions and Medicaid from guaranty
17 association coverage;
18 ▸ specifies that benefits provided by a long-term care rider to a life insurance policy or
19 annuity contract shall be considered the same type of benefits as the base life
20 insurance policy or annuity contract to which the rider relates;
21 ▸ excludes a policy or contract for an accident and health insurance benefit from the
22 "Moody's rollback" limitation on interest rates, credit rates, and other similar
23 factors;
24 ▸ increases the number of members on the guaranty association board of directors;
25 ▸ allows the guaranty association to file for justified rate increases;
26 ▸ addresses substitute coverage provided by the guaranty association for an indexed
27 policy or contract;
28 ▸ removes the $300 limit on Class A assessments;
29 ▸ provides that assessments for a long-term care insurer insolvency be shared with a

30 split of:

31 • 25% to accident and health member insurers; and

32 • 75% to the life insurance and annuity member insurers;

33 ▸ exempts a health maintenance organization from liability or assessment for a

34 long-term care insurer that becomes impaired or insolvent before January 1, 2021;

35 ▸ provides for the recoupment of assessments; and

36 ▸ makes technical and conforming changes.

37 **Money Appropriated in this Bill:**

38 None

39 **Other Special Clauses:**

40 This bill provides a special effective date.

41 **Utah Code Sections Affected:**

42 AMENDS:

43 **31A-8-103**, as last amended by Laws of Utah 2017, Chapter 292

44 **31A-27a-403**, as enacted by Laws of Utah 2007, Chapter 309

45 **31A-27a-701**, as last amended by Laws of Utah 2014, Chapters 290 and 300

46 **31A-27a-702**, as enacted by Laws of Utah 2007, Chapter 309

47 **31A-28-102**, as last amended by Laws of Utah 2001, Chapters 116 and 161

48 **31A-28-103**, as last amended by Laws of Utah 2010, Chapter 292

49 **31A-28-105**, as last amended by Laws of Utah 2010, Chapter 292

50 **31A-28-106**, as last amended by Laws of Utah 2006, Chapter 320

51 **31A-28-107**, as last amended by Laws of Utah 2011, Chapter 284

52 **31A-28-108**, as last amended by Laws of Utah 2010, Chapter 292

53 **31A-28-109**, as last amended by Laws of Utah 2010, Chapter 292

54 **31A-28-111**, as last amended by Laws of Utah 2010, Chapter 292

55 **31A-28-112**, as last amended by Laws of Utah 2010, Chapter 292

56 **31A-28-113**, as last amended by Laws of Utah 2011, Chapter 342

57 **31A-28-114**, as last amended by Laws of Utah 2010, Chapter 292

58 **31A-28-119**, as last amended by Laws of Utah 2010, Chapter 292

59 **31A-28-120**, as last amended by Laws of Utah 2010, Chapter 292

60 ENACTS:

61 **59-7-623**, Utah Code Annotated 1953

62

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

64 Section 1. Section **31A-8-103** is amended to read:

65 **31A-8-103. Applicability to other provisions of law.**

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

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

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

69 chapter:

70 (i) is wholly exempt from:

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

72 (B) Chapter 9, Insurance Fraternals;

73 (C) Chapter 10, Annuities;

74 (D) Chapter 11, Motor Clubs;

75 (E) Chapter 12, State Risk Management Fund; and

76 (F) Chapter 19a, Utah Rate Regulation Act; and

77 [~~(G) Chapter 28, Part 1, Utah Life and Health Insurance Guaranty Association Act;~~

78 ~~and~~]

79 (ii) is not subject to:

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

81 Insurance Department;

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

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

84 provisions specifically made applicable by this chapter;

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

86 this chapter;
87 (E) Chapter 17, Determination of Financial Condition, except:
88 (I) Part 2, Qualified Assets, and Part 6, Risk-Based Capital; or
89 (II) as made applicable by the commissioner by rule consistent with this chapter;
90 (F) Chapter 18, Investments, except as made applicable by the commissioner by rule
91 consistent with this chapter; and
92 (G) Chapter 22, Contracts in Specific Lines, except for Part 6, Accident and Health
93 Insurance, Part 7, Group Accident and Health Insurance, and Part 12, Reinsurance.
94 (2) The commissioner may by rule waive other specific provisions of this title that the
95 commissioner considers inapplicable to limited health plans, upon a finding that the waiver
96 will not endanger the interests of:
97 (a) enrollees;
98 (b) investors; or
99 (c) the public.
100 (3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16,
101 Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as
102 specifically made applicable by:
103 (a) this chapter;
104 (b) a provision referenced under this chapter; or
105 (c) a rule adopted by the commissioner to deal with corporate law issues of health
106 maintenance organizations that are not settled under this chapter.
107 (4) (a) Whenever in this chapter, Chapter 5, Domestic Stock and Mutual Insurance
108 Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization, the
109 application is:
110 (i) of those provisions that apply to a mutual corporation if the organization is
111 nonprofit; and
112 (ii) of those that apply to a stock corporation if the organization is for profit.
113 (b) When Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter

114 14, Foreign Insurers, is made applicable to an organization under this chapter, "mutual" means
115 nonprofit organization.
116 (5) Solicitation of enrollees by an organization is not a violation of any provision of
117 law relating to solicitation or advertising by health professionals if that solicitation is made in
118 accordance with:
119 (a) this chapter; and
120 (b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
121 Reinsurance Intermediaries.
122 (6) This title does not prohibit any health maintenance organization from meeting the
123 requirements of any federal law that enables the health maintenance organization to:
124 (a) receive federal funds; or
125 (b) obtain or maintain federal qualification status.
126 (7) Except as provided in Chapter 45, Managed Care Organizations, an organization is
127 exempt from statutes in this title or department rules that restrict or limit the organization's
128 freedom of choice in contracting with or selecting health care providers, including Section
129 31A-22-618.
130 (8) An organization is exempt from the assessment or payment of premium taxes
131 imposed by Sections 59-9-101 through 59-9-104.
132 Section 2. Section **31A-27a-403** is amended to read:
133 **31A-27a-403. Continuance of coverage -- Health maintenance organizations.**
134 (1) As used in this section:
135 (a) "Basic health care services" is as defined in Section 31A-8-101.
136 (b) "Enrollee" is as defined in Section 31A-8-101.
137 (c) "Health care" is as defined in Section 31A-1-301.
138 (d) "Health maintenance organization" is as defined in Section 31A-8-101.
139 (e) "Limited health plan" is as defined in Section 31A-8-101.
140 (f) (i) "Managed care organization" means an entity licensed by, or holding a certificate
141 of authority from, the department to furnish health care services or health insurance.

142 (ii) "Managed care organization" includes:
143 (A) a limited health plan;
144 (B) a health maintenance organization;
145 (C) a preferred provider organization;
146 (D) a fraternal benefit society; or
147 (E) an entity similar to an entity described in Subsections (1)(f)(ii)(A) through (D).
148 (iii) "Managed care organization" does not include:
149 (A) an insurer or other person that is eligible for membership in a guaranty association
150 under Chapter 28, Guaranty Associations;
151 (B) a mandatory state pooling plan;
152 (C) a mutual assessment company or an entity that operates on an assessment basis; or
153 (D) an entity similar to an entity described in Subsections (1)(f)(iii)(A) through (C).
154 (g) "Participating provider" means a provider who, under a contract with a managed
155 care organization authorized under Section 31A-8-407, agrees to provide health care services to
156 enrollees with an expectation of receiving payment:
157 (i) directly or indirectly, from the managed care organization; and
158 (ii) other than a copayment.
159 (h) "Participating provider contract" means the agreement between a participating
160 provider and a managed care organization authorized under Section 31A-8-407.
161 (i) "Preferred provider" means a provider who agrees to provide health care services
162 under an agreement authorized under Subsection 31A-22-617(1).
163 (j) "Preferred provider contract" means the written agreement between a preferred
164 provider and a managed care organization authorized under Subsection 31A-22-617(1).
165 (k) (i) Except as provided in Subsection (1)(k)(ii), "preferred provider organization"
166 means a person that:
167 (A) furnishes at a minimum, through a preferred provider, basic health care services to
168 an enrollee in return for prepaid periodic payments in an amount agreed to before the time
169 during which the health care may be furnished;

170 (B) is obligated to the enrollee to arrange for the services described in Subsection
171 (1)(k)(i)(A); and
172 (C) permits the enrollee to obtain health care services from a provider who is not a
173 preferred provider.
174 (ii) "Preferred provider organization" does not include:
175 (A) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance
176 Corporations; or
177 (B) an individual who contracts to render professional or personal services that the
178 individual performs.
179 (l) "Provider" is as defined in Section 31A-8-101.
180 (m) "Uncovered expenditure" means a cost of health care services that is covered by an
181 organization for which an enrollee is liable in the event of the managed care organization's
182 insolvency.
183 (2) The rehabilitator or liquidator may take one or more of the actions described in
184 Subsections (2)(a) through (g) to assure continuation of health care coverage for enrollees of an
185 insolvent managed care organization.
186 (a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a
187 participating provider or preferred provider to continue to provide the health care services the
188 provider is required to provide under the provider's participating provider contract or preferred
189 provider contract until the earlier of:
190 (A) 90 days after the day on which the following is filed:
191 (I) a petition for rehabilitation; or
192 (II) a petition for liquidation; or
193 (B) the day on which the term of the contract ends.
194 (ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a
195 participating provider or preferred provider continue to provide health care services under the
196 provider's participating provider contract or preferred provider contract expires when health
197 care coverage for all enrollees of the insolvent managed care organization is obtained from

198 another managed care organization or insurer.
199 (b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees
200 a participating provider or preferred provider is otherwise entitled to receive from the managed
201 care organization under the provider's participating provider contract or preferred provider
202 contract during the time period in Subsection (2)(a)(i).
203 (ii) Notwithstanding Subsection (2)(b)(i), a rehabilitator or liquidator may not reduce a
204 fee to less than 75% of the regular fee set forth in the provider's participating provider contract
205 or preferred provider contract.
206 (iii) An enrollee shall continue to pay the same copayments, deductibles, and other
207 payments for services received from a participating provider or preferred provider that the
208 enrollee is required to pay before the day on which the following is filed:
209 (A) the petition for rehabilitation; or
210 (B) the petition for liquidation.
211 (c) A participating provider or preferred provider shall:
212 (i) accept the amounts specified in Subsection (2)(b) as payment in full; and
213 (ii) relinquish the right to collect additional amounts from the insolvent managed care
214 organization's enrollee.
215 (d) Subsections (2)(b) and (c) apply to the fees paid to a provider who agrees to
216 provide health care services to an enrollee but is not a preferred or participating provider.
217 [~~(e) If the managed care organization is a health maintenance organization, Subsections~~
218 ~~(2)(e)(i) through (vi) apply.~~]
219 (e) This Subsection (2)(e) applies to a managed care organization that is a health
220 maintenance organization for a delinquency proceeding under this chapter that is initiated
221 before May 8, 2018.
222 (i) A solvent health maintenance organization licensed under Chapter 8, Health
223 Maintenance Organizations and Limited Health Plans, shall extend to the enrollees of an
224 insolvent health maintenance organization all rights, privileges, and obligations of being an
225 enrollee in the accepting health maintenance organization:

226 (A) subject to Subsections (2)(e)(ii), (iii), and (v);

227 (B) upon notification from and subject to the direction of the rehabilitator or liquidator
228 of an insolvent health maintenance organization licensed under Chapter 8, Health Maintenance
229 Organizations and Limited Health Plans; and

230 (C) if the solvent health maintenance organization operates within a portion of the
231 insolvent health maintenance organization's service area.

232 (ii) Notwithstanding Subsection (2)(e)(i), the accepting health maintenance
233 organization shall give credit to an enrollee for any waiting period already satisfied under the
234 enrollee's contract with the insolvent health maintenance organization.

235 (iii) A health maintenance organization accepting an enrollee of an insolvent health
236 maintenance organization under Subsection (2)(e)(i) shall charge the enrollee the premiums
237 applicable to the existing business of the accepting health maintenance organization.

238 (iv) A health maintenance organization's obligation to accept an enrollee under
239 Subsection (2)(e)(i) is limited in number to the accepting health maintenance organization's pro
240 rata share of all health maintenance organization enrollees in this state, as determined after
241 excluding the enrollees of the insolvent insurer.

242 (v) (A) The rehabilitator or liquidator of an insolvent health maintenance organization
243 shall take those measures that are possible to ensure that no health maintenance organization is
244 required to accept more than its pro rata share of the adverse risk represented by the enrollees
245 of the insolvent health maintenance organization.

246 (B) If the methodology used by the rehabilitator or liquidator to assign an enrollee is
247 one that can be expected to produce a reasonably equitable distribution of adverse risk, that
248 methodology and its results are acceptable under this Subsection (2)(e)(v).

249 (vi) (A) Notwithstanding Section 31A-27a-402, the rehabilitator or liquidator may
250 require all solvent health maintenance organizations to pay for the covered claims incurred by
251 the enrollees of the insolvent health maintenance organization.

252 (B) As determined by the rehabilitator or liquidator, payments required under this
253 Subsection (2)(e)(vi) may:

254 (I) begin as of the day on which the following is filed:
255 (Aa) the petition for rehabilitation; or
256 (Bb) the petition for liquidation; and
257 (II) continue for a maximum period through the time all enrollees are assigned pursuant
258 to this section.
259 (C) If the rehabilitator or liquidator makes an assessment under this Subsection
260 (2)(e)(vi), the rehabilitator or liquidator shall assess each solvent health maintenance
261 organization its pro rata share of the total assessment based upon its premiums from the
262 previous calendar year.
263 (D) (I) A solvent health maintenance organization required to pay for covered claims
264 under this Subsection (2)(e)(vi) may file a claim against the estate of the insolvent health
265 maintenance organization.
266 (II) Any claim described in Subsection (2)(e)(vi)(D)(I), if allowed by the rehabilitator
267 or liquidator, shall share in any distributions from the estate of the insolvent health
268 maintenance organization as a Class 3 claim.
269 (f) (i) A rehabilitator or liquidator may transfer, through sale or otherwise, the group
270 and individual health care obligations of the insolvent managed care organization to one or
271 more other managed care organizations or other insurers, if those other managed care
272 organizations and other insurers:
273 (A) are licensed to provide the same health care services in this state that are held by
274 the insolvent managed care organization; or
275 (B) have a certificate of authority to provide the same health care services in this state
276 that is held by the insolvent managed care organization.
277 (ii) The rehabilitator or liquidator may combine group and individual health care
278 obligations of the insolvent managed care organization in any manner the rehabilitator or
279 liquidator considers best to provide for continuous health care coverage for the maximum
280 number of enrollees of the insolvent managed care organization.
281 (iii) If the terms of a proposed transfer of the same combination of group and

282 individual policy obligations to more than one other managed care organization or insurer are
283 otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group
284 and individual policy obligations of an insolvent managed care organization as follows:
285 (A) from one category of managed care organization to another managed care
286 organization of the same category, as follows:
287 (I) from a limited health plan to a limited health plan;
288 (II) from a health maintenance organization to a health maintenance organization;
289 (III) from a preferred provider organization to a preferred provider organization;
290 (IV) from a fraternal benefit society to a fraternal benefit society; and
291 (V) from an entity similar to an entity described in this Subsection (2)(f)(iii)(A) to a
292 category that is similar;
293 (B) from one category of managed care organization to another managed care
294 organization, regardless of the category of the transferee managed care organization; and
295 (C) from a managed care organization to a nonmanaged care provider of health care
296 coverage, including insurers.
297 (g) If an insolvent managed care organization has required surplus, a rehabilitator or
298 liquidator may use the insolvent managed care organization's required surplus to continue to
299 provide coverage for the insolvent managed care organization's enrollees, including paying
300 uncovered expenditures.
301 Section 3. Section **31A-27a-701** is amended to read:
302 **31A-27a-701. Priority of distribution.**
303 (1) (a) The priority of payment of distributions on unsecured claims shall be in
304 accordance with the order in which each class of claim is set forth in this section except as
305 provided in Section 31A-27a-702.
306 (b) All claims in each class shall be paid in full or adequate funds retained for the
307 claim's payment before a member of the next class receives payment.
308 (c) All claims within a class shall be paid substantially the same percentage.
309 (d) Except as provided in Subsections (2)(a)(i)(E), (2)(k), and (2)(m), subclasses may

310 not be established within a class.
311 (e) A claim by a shareholder, policyholder, or other creditor may not be permitted to
312 circumvent the priority classes through the use of equitable remedies.
313 (2) The order of distribution of claims shall be as follows:
314 (a) a Class 1 claim, which:
315 (i) is a cost or expense of administration expressly approved or ratified by the
316 liquidator, including the following:
317 (A) the actual and necessary costs of preserving or recovering the property of the
318 insurer;
319 (B) reasonable compensation for all services rendered on behalf of the administrative
320 supervisor or receiver;
321 (C) a necessary filing fee;
322 (D) the fees and mileage payable to a witness;
323 (E) an unsecured loan obtained by the receiver, which:
324 (I) unless its terms otherwise provide, has priority over all other costs of
325 administration; and
326 (II) absent agreement to the contrary, shares pro rata with all other claims described in
327 this Subsection (2)(a)(i)(E); and
328 (F) an expense approved by the rehabilitator of the insurer, if any, incurred in the
329 course of the rehabilitation that is unpaid at the time of the entry of the order of liquidation; and
330 (ii) except as expressly approved by the receiver, excludes any expense arising from a
331 duty to indemnify a director, officer, or employee of the insurer which expense, if allowed, is a
332 Class 7 claim;
333 (b) a Class 2 claim, which:
334 (i) is a reasonable expense of a guaranty association, including overhead, salaries, or
335 other general administrative expenses allocable to the receivership such as:
336 (A) an administrative or claims handling expense;
337 (B) an expense in connection with arrangements for ongoing coverage; and

338 (C) in the case of a property and casualty guaranty association, a loss adjustment
339 expense, including:
340 (I) an adjusting or other expense; and
341 (II) a defense or cost containment expense; and
342 (ii) excludes an expense incurred in the performance of duties under Section
343 31A-28-112 or similar duties under the statute governing a similar organization in another
344 state;
345 (c) a Class 3 claim, which:
346 (i) is:
347 (A) a claim under a policy of insurance including a third party claim;
348 (B) a claim under an annuity contract or funding agreement;
349 (C) a claim under a nonassessable policy for unearned premium;
350 (D) a claim of an obligee and, subject to the discretion of the receiver, a completion
351 contractor under a surety bond or surety undertaking, except for:
352 (I) a bail bond;
353 (II) a mortgage guaranty;
354 (III) a financial guaranty; or
355 (IV) other form of insurance offering protection against investment risk or warranties;
356 (E) a claim by a principal under a surety bond or surety undertaking for wrongful
357 dissipation of collateral by the insurer or its agents;
358 (F) an indemnity payment on:
359 (I) a covered claim; or
360 (II) for a delinquency proceeding under this chapter that is initiated before May 8,
361 2018, a payment for the continuation of coverage made by an entity responsible for the
362 payment of a claim or continuation of coverage of an insolvent health maintenance
363 organization;
364 (G) a claim for unearned premium;
365 (H) a claim incurred during the extension of coverage provided for in Sections

366 31A-27a-402 and 31A-27a-403; or
367 (I) all other claims incurred in fulfilling the statutory obligations of a guaranty
368 association not included in Class 2, including:
369 (I) an indemnity payment on covered claims; and
370 (II) in the case of a life and health guaranty association, a claim:
371 (Aa) as a creditor of the impaired or insolvent insurer for a payment of and liabilities
372 incurred on behalf of a covered claim or covered obligation of the insurer; and
373 (Bb) for the funds needed to reinsure the obligations described under this Subsection
374 (2)(c)(i)(I)(II) with a solvent insurer; and
375 (ii) notwithstanding any other provision of this chapter, excludes the following which
376 shall be paid under Class 7, except as provided in this section:
377 (A) an obligation of the insolvent insurer arising out of a reinsurance contract;
378 (B) an obligation that is incurred pursuant to an occurrence policy or reported pursuant
379 to a claims made policy after:
380 (I) the expiration date of the policy;
381 (II) the policy is replaced by the insured;
382 (III) the policy is canceled at the insured's request; or
383 (IV) the policy is canceled as provided in this chapter;
384 (C) an obligation to an insurer, insurance pool, or underwriting association and the
385 insurer's, insurance pool's, or underwriting association's claim for contribution, indemnity, or
386 subrogation, equitable or otherwise, except for direct claims under a policy where the insurer is
387 the named insured;
388 (D) an amount accrued as punitive or exemplary damages unless expressly covered
389 under the terms of the policy, which shall be paid as a claim in Class 9;
390 (E) a tort claim of any kind against the insurer;
391 (F) a claim against the insurer for bad faith or wrongful settlement practices; and
392 (G) a claim of a guaranty association for assessments not paid by the insurer, which
393 claims shall be paid as claims in Class 7; and

394 (iii) notwithstanding Subsection (2)(c)(ii)(B), does not exclude an unearned premium
395 claim on a policy, other than a reinsurance agreement;
396 (d) a Class 4 claim, which is a claim under a policy for mortgage guaranty, financial
397 guaranty, or other forms of insurance offering protection against investment risk or warranties;
398 (e) a Class 5 claim, which is a claim of the federal government not included in Class 3
399 or 4;
400 (f) a Class 6 claim, which is a debt due an employee for services or benefits:
401 (i) to the extent that the expense:
402 (A) does not exceed the lesser of:
403 (I) $5,000; or
404 (II) two months' salary; and
405 (B) represents payment for services performed within one year before the day on which
406 the initial order of receivership is issued; and
407 (ii) which priority is in lieu of any other similar priority that may be authorized by law
408 as to wages or compensation of employees;
409 (g) a Class 7 claim, which is a claim of an unsecured creditor not included in Classes 1
410 through 6, including:
411 (i) a claim under a reinsurance contract;
412 (ii) a claim of a guaranty association for an assessment not paid by the insurer; and
413 (iii) other claims excluded from Class 3 or 4, unless otherwise assigned to Classes 8
414 through 13;
415 (h) subject to Subsection (3), a Class 8 claim, which is:
416 (i) a claim of a state or local government, except a claim specifically classified
417 elsewhere in this section; or
418 (ii) a claim for services rendered and expenses incurred in opposing a formal
419 delinquency proceeding;
420 (i) a Class 9 claim, which is a claim for penalties, punitive damages, or forfeitures,
421 unless expressly covered under the terms of a policy of insurance;

422 (j) a Class 10 claim, which is, except as provided in Subsections 31A-27a-601(2) and
423 31A-27a-601(3), a late filed claim that would otherwise be classified in Classes 3 through 9;
424 (k) subject to Subsection (4), a Class 11 claim, which is:
425 (i) a surplus note;
426 (ii) a capital note;
427 (iii) a contribution note;
428 (iv) a similar obligation;
429 (v) a premium refund on an assessable policy; or
430 (vi) any other claim specifically assigned to this class;
431 (l) a Class 12 claim, which is a claim for interest on an allowed claim of Classes 1
432 through 11, according to the terms of a plan to pay interest on allowed claims proposed by the
433 liquidator and approved by the receivership court; and
434 (m) subject to Subsection (4), a Class 13 claim, which is a claim of a shareholder or
435 other owner arising out of:
436 (i) the shareholder's or owner's capacity as shareholder or owner or any other capacity;
437 and
438 (ii) except as the claim may be qualified in Class 3, 4, 7, or 12.
439 (3) To prove a claim described in Class 8, the claimant shall show that:
440 (a) the insurer that is the subject of the delinquency proceeding incurred the fee or
441 expense on the basis of the insurer's best knowledge, information, and belief:
442 (i) formed after reasonable inquiry indicating opposition is in the best interests of the
443 insurer;
444 (ii) that is well grounded in fact; and
445 (iii) is warranted by existing law or a good faith argument for the extension,
446 modification, or reversal of existing law; and
447 (b) opposition is not pursued for any improper purpose, such as to harass, to cause
448 unnecessary delay, or to cause needless increase in the cost of the litigation.
449 (4) (a) A claim in Class 11 is subject to a subordination agreement related to other

450 claims in Class 11 that exist before the entry of a liquidation order.

451 (b) A claim in Class 13 is subject to a subordination agreement, related to other claims

452 in Class 13 that exist before the entry of a liquidation order.

453 Section 4. Section **31A-27a-702** is amended to read:

454 **31A-27a-702. Health maintenance organization claims.**

455 (1) [In] For a delinquency proceeding under this chapter that is initiated before May 8,

456 2018, in the liquidation of a health maintenance organization, a claim for uncovered

457 expenditures has priority over a Class 3 claim as provided for in Section 31A-27a-701.

458 (2) A claim other than one described in Subsection (1) shall follow the priority of

459 distribution outlined in Section 31A-27a-701.

460 Section 5. Section **31A-28-102** is amended to read:

461 **31A-28-102. Purpose.**

462 (1) The purpose of this part is to protect, subject to certain limitations, the persons

463 specified in [Subsection] Subsections 31A-28-103(1) through (5) against failure in the

464 performance of contractual obligations, under a life [and] insurance, accident and health

465 insurance [policy], or annuity policy or contract specified in [Subsection] Subsections

466 31A-28-103[(2)](6) and (7), because of the impairment or insolvency of the member insurer

467 that issued the policy or contract.

468 (2) To provide the protection described in Subsection (1):

469 (a) the Utah Life and Health Insurance Guaranty Association, which currently exists, is

470 continued to pay benefits and to continue coverages as limited by this part; and

471 (b) members of the association are subject to assessment to provide funds to carry out

472 the purpose of this part.

473 Section 6. Section **31A-28-103** is amended to read:

474 **31A-28-103. Coverage and limitations.**

475 (1) [(a)] This part provides coverage for a policy or contract specified in [Subsection

476 (2)] Subsections (6) and (7) to a person who is:

477 [(i)] (a) except for a nonresident certificate holder under a group policy or contract, a

478 beneficiary, assignee, or payee of a person covered by Subsection [(1)(a)(ii)] (1)(b), including a
479 health care provider rendering services covered under an accident and health insurance policy
480 or certificate, regardless of where that person resides[, except for a nonresident certificate
481 holder under a group policy or contract]; or
482 [(ii)] (b) an owner of or a certificate holder or enrollee under a policy or contract, other
483 than an unallocated annuity contract or structured settlement annuity, if the owner, enrollee, or
484 certificate holder is:
485 [(A)] (i) a resident of Utah; or
486 [(B)] (ii) not a resident of Utah, but only if:
487 [(I)] (A) the member insurer that issued the policy or contract is domiciled in this state;
488 [(II)] (B) the state in which the person resides has an association similar to the
489 association created by this part; and
490 [(III)] (C) the person is not eligible for coverage by an association in any other state
491 because the insurer was not licensed in the [state] other states at the time specified in the
492 [state's] other states' guaranty association's [law] laws.
493 [(b)] (2) For an unallocated annuity contract specified in [Subsection (2)] Subsections
494 (6) and (7):
495 [(i)] (a) Subsection (1)[(a)] does not apply; and
496 [(ii)] (b) except as provided in Subsections [(1)(d) and (1)(e)] (4) and (5), this part
497 provides coverage for the unallocated annuity contract specified in Subsection (2) to a person
498 who is:
499 [(A)] (i) the owner of the unallocated annuity contract if the contract is issued to or in
500 connection with a specific benefit plan whose plan sponsor has its principal place of business
501 in this state; [and] or
502 [(B)] (ii) an owner of an unallocated annuity contract issued to or in connection with a
503 government lottery if the owner is a resident.
504 [(c)] (3) For a structured settlement annuity specified in [Subsection (2)] Subsections
505 (6) and (7):

506 [(i)] (a) Subsection (1)[(a)] does not apply; and
507 [(ii)] (b) except as provided in Subsections [(1)(d) and (1)(e)] (4) and (5), this part
508 provides coverage for the structured settlement annuity specified in [Subsection (2)]
509 Subsections (6) and (7) to a person who is a payee under a structured settlement annuity, or
510 beneficiary of a payee if the payee is deceased, if the payee:
511 [(A)] (i) is a resident, regardless of where the contract owner resides; [or]
512 [(B)] (ii) is not a resident, but only if one or more of the contract owners of the
513 structured settlement annuity is a resident, and the payee, beneficiary, or contract owner is not
514 eligible for coverage by the association of the state in which the payee or contract owner
515 resides; or
516 (iii) is not a resident, but only if:
517 (A) no contract owner of the structured settlement annuity is a resident[, but:];
518 [(I)] (B) the insurer that issued the structured settlement annuity is domiciled in this
519 state;
520 [(II)] (C) the state in which the contract owner resides has an association similar to the
521 association created by this part; and
522 [(III)] (D) the payee, beneficiary, or the contract owner is not eligible for coverage by
523 the association of the state in which the payee or contract owner resides.
524 [(d)] (4) This part may not provide coverage for a policy or contract specified in
525 [Subsection (2) to] Subsections (6) and (7) to a person who:
526 [(i)] (a) [a person who] is a payee or beneficiary of a contract owner resident of this
527 state, if the payee or beneficiary is afforded any coverage by the association of another state;
528 [or]
529 [(ii)] (b) [a person] is covered under Subsection [(1)(b)] (2), if any coverage is
530 provided to the person by the association of another state[.]; or
531 (c) acquires rights to receive payments through a structured settlement factoring
532 transaction, regardless of whether the transaction occurred before or after 26 U.S.C. Sec.
533 5891(c)(3)(A) became effective.

534 [(c) (i)] (5) (a) This part provides coverage for a policy or contract specified in
535 [Subsection (2)] Subsections (6) and (7) to a person who is a resident of this state and, in
536 special circumstances, to a nonresident.
537 [(ii)] (b) To avoid duplicate coverage, if a person who would otherwise receive
538 coverage under this part is provided coverage under the laws of any other state, the person may
539 not be provided coverage under this part.
540 [(iii)] (c) In determining the application of this Subsection [(1)(c)] (5) when a person
541 could be covered by the association of more than one state, whether as an owner, payee,
542 enrollee, beneficiary, or assignee, this part shall be construed in conjunction with other state
543 laws to result in coverage by only one association.
544 [(2) (a) (i)] (6) (a) Except as limited by this part, this part provides coverage to a person
545 specified in [Subsection (1)] Subsections (1) through (5) for:
546 [(A)] (i) a direct[,] nongroup life insurance, direct accident and health insurance, or
547 direct annuity policy or contract;
548 [(B)] (ii) a supplemental contract to a policy or contract described in Subsection
549 [(2)(a)(i)(A)] (6)(a)(i);
550 [(C)] (iii) a certificate under a direct group policy or contract; and
551 [(D)] (iv) an unallocated annuity contract issued by a member insurer.
552 [(ii)] (b) For purposes of Subsection [(2)(a)(i)] (6)(a), an annuity contract and a
553 certificate under a group annuity contract includes:
554 [(A)] (i) a guaranteed investment contract;
555 [(B)] (ii) a deposit administration contract;
556 [(C)] (iii) an unallocated funding agreement;
557 [(D)] (iv) an allocated funding agreement;
558 [(E)] (v) a structured settlement annuity;
559 [(F)] (vi) an annuity issued to or in connection with a government lottery; and
560 [(G)] (vii) an immediate or deferred annuity contract.
561 [(b)] (7) This part does not provide coverage for:

562 [(i)] (a) a portion of a policy or contract:
563 [(A)] (i) not guaranteed by the member insurer; or
564 [(B)] (ii) under which the risk is borne by the policy or contract owner;
565 [(ii)] (b) a policy or contract of reinsurance, unless:
566 [(A)] (i) an assumption certificate is issued before the coverage date;
567 [(B)] (ii) the assumption certificate required by Subsection [(2)(b)(ii)(A)] (7)(b)(i) is in
568 effect pursuant to the reinsurance policy or contract; and
569 [(C)] (iii) the reinsurance contract is approved by the appropriate regulatory authorities;
570 [(iii)] (c) except as provided in Subsection (11)(e), a portion of a policy or contract to
571 the extent that the rate of interest on which [it] the policy or contract is based, or the interest
572 rate, crediting rate, or similar factor determined by use of an index or other external reference
573 stated in the policy or contract employed in calculating returns or changes in value[, if the
574 interest rate, crediting rate, or similar factor] exceeds:
575 [(A) is not excluded from coverage by Subsection (2)(b)(xi);]
576 [(B) averaged over the period of four years before the date on which the association
577 becomes obligated with respect to the policy or contract, exceeds]
578 (i) a rate of interest determined by subtracting two percentage points from Moody's
579 Corporate Bond Yield Average averaged:
580 [(I) for that same four-year period; or]
581 (A) over the period of four years before the coverage date with respect to the policy or
582 contract; or
583 [(II)] (B) for the corresponding lesser period if the policy or contract was issued less
584 than four years before the association became obligated; [and] or
585 [(C)] (ii) [exceeds the] a rate of interest determined by subtracting three percentage
586 points from Moody's Corporate Bond Yield Average as most recently available as determined
587 on or after the earlier of [the day on which the member insurer becomes]:
588 [(I)] (A) the day on which the member insurer becomes an impaired insurer [under this
589 part]; or

590 [(II)] (B) the day on which the member insurer becomes an insolvent insurer [under
591 this part];
592 [(iv)] (d) a portion of a policy or contract issued to a plan or program of an employer,
593 association, or other person to provide life, accident and health, or annuity benefits to its
594 employees, members, or others, to the extent that the plan or program is self-funded or
595 uninsured, including benefits payable by an employer, association, or other person under:
596 [(A)] (i) a multiple employer welfare arrangement, as that term is defined in 29 U.S.C.
597 Sec. [1144] 1002;
598 [(B)] (ii) a minimum premium group insurance plan;
599 [(C)] (iii) a stop-loss group insurance plan; or
600 [(D)] (iv) an administrative services only contract;
601 [(v)] (e) a portion of a policy or contract to the extent that it provides:
602 [(A)] (i) a dividend;
603 [(B)] (ii) an experience rating credit;
604 [(C)] (iii) voting rights; or
605 [(D)] (iv) payment of a fee or allowance to any person, including the policy or contract
606 owner, in connection with the service to or administration of the policy or contract;
607 [(vi)] (f) an unallocated annuity contract issued to or in connection with a benefit plan
608 protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the
609 federal Pension Benefit Guaranty Corporation has yet become liable to make any payment with
610 respect to the benefit plan;
611 [(vii)] (g) a portion of an unallocated annuity contract that is not issued to or in
612 connection with:
613 [(A)] (i) a specific benefit plan of:
614 [(I)] (A) employees;
615 [(II)] (B) a union; or
616 [(III)] (C) an association of natural persons; or
617 [(B)] (ii) a government lottery;

618 [(viii)] (h) a portion of a policy or contract to the extent that the assessment required by
619 Section 31A-28-109 that applies to the policy or contract is preempted by federal or state law;
620 [(ix)] (i) an obligation that does not arise under the express written terms of the policy
621 or contract issued by [an] a member insurer to the enrollee, certificate holder, contract owner,
622 or policy owner, including:
623 [(A)] (i) a claim based on marketing materials;
624 [(B)] (ii) a claim based on a side letter, rider, or other document that is issued by the
625 member insurer without meeting applicable policy or contract form filing or approval
626 requirements;
627 [(C)] (iii) a misrepresentation regarding a policy or contract benefit;
628 [(D)] (iv) an extra-contractual claim;
629 [(E)] (v) a claim for penalties; or
630 [(F)] (vi) a claim for consequential or incidental damages;
631 [(x)] (j) a contract that establishes the member insurer's obligations to provide a book
632 value accounting guaranty for defined contribution benefit plan participants by reference to a
633 portfolio of assets that is owned by a person that is:
634 [(A) (I)] (i) (A) the benefit plan; or
635 [(II)] (B) the benefit plan's trustee; and
636 [(B)] (ii) not an affiliate of the member insurer;
637 [(xi)] (k) a portion of a policy or contract to the extent it provides for interest or other
638 changes in value:
639 [(A)] (i) to be determined by the use of an index or other external reference stated in
640 the policy or contract; and
641 (ii) as of the date the member insurer becomes an impaired or insolvent insurer,
642 whichever occurs earlier:
643 [(B) (I)] (A) that have not been credited to the policy or contract; or
644 [(II)] (B) as to which the policy or contract owner's rights are subject to forfeiture [as of
645 the date the member insurer becomes an impaired or insolvent insurer under this part; and];

646 [(xii)] (l) a policy or contract providing hospital, medical, prescription drug, or other
647 health care benefit pursuant to [United States Code, Title 42, Subchapter XVIII, Chapter 7, Part
648 C or D, or federal regulations issued under Part C or D.]:
649 (i) Part C or D of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.; or
650 (ii) Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq.; or
651 (m) a structured settlement annuity benefit to which a payee or beneficiary has
652 transferred the payee or beneficiary's rights in a structured settlement factoring transaction,
653 regardless of whether the transaction occurred before or after 26 U.S.C. Sec. 5891(c)(3)(A)
654 became effective.
655 [(3)] (8) [Subject to Subsection (4), the] The benefits for which the association may
656 become liable may not exceed the lesser of:
657 (a) the contractual obligations for which the member insurer is liable or would have
658 been liable if it were not an impaired or insolvent insurer;
659 (b) with respect to one life, regardless of the number of policies or contracts:
660 (i) for a life insurance policy:
661 (A) if the insured died before the coverage date, $500,000 of the death benefit;
662 (B) if the insurer received a valid request for cash surrender before the coverage date
663 but has not paid the cash surrender value before the coverage date, $200,000 of cash surrender
664 benefits; or
665 (C) if neither Subsection [(3)] (8)(b)(i)(A) nor (B) [apply] applies, the covered portion
666 of each benefit provided under the policy;
667 (ii) for an annuity contract, the covered portion of each benefit provided under the
668 contract; and
669 (iii) for an accident and health insurance policy or contract:
670 (A) classified as [health insurance] a health benefit plan, $500,000; or
671 (B) not classified as [health insurance] a health benefit plan, the covered portion of
672 each benefit provided under the policy;
673 (c) for an individual[, or a beneficiary of that individual if the individual is deceased,]

674 participating in a governmental retirement plan established under Section 401, 403(b), or 457,
675 Internal Revenue Code, covered by an unallocated annuity contract, [~~in the aggregate~~] or a
676 beneficiary of that individual if the individual is deceased, $250,000 in present value of annuity
677 benefits, in the aggregate, including:
678 (i) net cash surrender; and
679 (ii) net cash withdrawal values; or
680 (d) for a payee of a structured settlement annuity or a beneficiary of the payee if the
681 payee is deceased, the limits set forth in Subsection [~~(3)~~] (8)(b).
682 [~~(4)~~] (9) Notwithstanding [~~Subsections (3)(a) through (d)~~] Subsection (8), the
683 association may not be obligated to cover more than:
684 (a) an aggregate of $500,000 in benefits for any one life under:
685 (i) Subsection [~~(3)~~] (8)(b)(i)(A);
686 (ii) Subsection [~~(3)~~] (8)(b)(i)(B);
687 (iii) Subsection [~~(3)~~] (8)(b)(ii); and
688 (iv) Subsection [~~(3)~~] (8)(b)(iii)(B);
689 (b) $5,000,000 in benefits for one owner of multiple nongroup policies of life
690 insurance:
691 (i) whether the policy or contract owner is an individual, firm, corporation, or other
692 person;
693 (ii) whether the persons insured are officers, managers, employees, or other persons;
694 and
695 (iii) regardless of the number of policies and contracts held by the owner; and
696 (c) $5,000,000 in benefits, regardless of the number of contracts held by the contract
697 owner or plan sponsor, for:
698 (i) one contract owner provided coverage under Subsection [~~(1)(b)(ii)(B)~~] (2)(b)(ii); or
699 (ii) one plan sponsor whose plans own, directly or in trust, one or more unallocated
700 annuity contracts not included in Subsection [~~(3)~~] (8)(b)(ii).
701 [~~(5)~~] (10) (a) Notwithstanding Subsection [~~(4)~~] (9)(c) and except as provided in

702 Subsection [(5)] (10)(b), the association shall provide coverage if one or more unallocated
703 annuity contracts are:
704 (i) covered contracts under this part;
705 (ii) owned by a trust or other entity for the benefit of two or more plan sponsors; and
706 (iii) the largest interest in the trust or entity owning the contract or contracts is held by
707 a plan sponsor whose principal place of business is in the state.
708 (b) [Notwithstanding Subsection (5)(a) the] The association may not be obligated to
709 cover more than $5,000,000 in benefits with respect to the unallocated contracts described in
710 Subsection [(5)] (10)(a).
711 [(6)] (11) (a) The limitations set forth in Subsections [(3) and (4)] (8) and (9) are
712 limitations on the benefits for which the association is obligated before taking into account:
713 (i) the association's subrogation and assignment rights; or
714 (ii) the extent to which those benefits could be provided out of the assets of the
715 impaired or insolvent insurer attributable to covered policies.
716 (b) The costs of the association's obligations under this part may be met by the use of
717 assets:
718 (i) attributable to covered policies, as described in Subsection 31A-28-114(3)(c); or
719 (ii) reimbursed to the association pursuant to the association's subrogation and
720 assignment rights.
721 [(c) On and after the date on which the association becomes obligated for a covered
722 policy, the association may not be obligated to provide benefits to the extent that the benefits
723 are based on an interest rate, crediting rate, or similar factor determined by use of an index or
724 other external reference stated in the policy or contract employed in calculating returns or
725 changes in value if the interest rate, crediting rate, or similar factor exceeds the rate of interest
726 determined by subtracting three percentage points from Moody's Corporate Bond Yield
727 Average as most recently available on each date on which interest is credited or attributed to
728 the covered policy.]
729 (c) Benefits provided by a long-term care rider to a life insurance policy or annuity

730 contract shall be considered the same type of benefits as the base life insurance policy or
731 annuity contract to which the long-term care rider relates.
732 (d) In performing its obligations to provide coverage under Section 31A-28-108, the
733 association may not be required to guarantee, assume, reinsure, reissue, perform, or cause to be
734 guaranteed, assumed, reinsured, reissued, or performed a contractual obligation of the insolvent
735 or impaired insurer under a covered policy or contract that does not materially affect the
736 economic values or economic benefits of the covered policy or contract.
737 (e) The exclusion from coverage described in Subsection (7)(c) does not apply to any
738 portion of a policy or contract, including a rider, that provides long-term care or any other
739 accident and health insurance benefit.
740 Section 7. Section **31A-28-105** is amended to read:
741 **31A-28-105. Definitions.**
742 As used in this part:
743 (1) "Association" means the Utah Life and Health Insurance Guaranty Association
744 continued under Section 31A-28-106.
745 (2) (a) "Authorized assessment" or "authorized," when used in the context of
746 assessments, means that the board of directors passed a resolution [whereby] by which an
747 assessment will be called immediately or in the future from member insurers for an amount [set
748 forth] specified in the resolution.
749 (b) An assessment is authorized when the resolution is passed.
750 (3) "Benefit plan" means a specific benefit plan of:
751 (a) employees;
752 (b) a union; or
753 (c) an association of natural persons.
754 (4) "Board of directors" means the board of directors established under Section
755 31A-28-107.
756 [(4)] (5) (a) "Called assessment" or "called," when used in the context of assessments,
757 means that the association issued a notice to member insurers requiring that an authorized

758 assessment be paid within the time frame set forth in the notice.
759 (b) All or part of an authorized assessment becomes a called assessment when notice is
760 mailed by the association to member insurers.
761 [~~(5)~~] (6) "Cash surrender value" means the cash surrender value without reduction for
762 an outstanding policy loan or surrender charge.
763 [~~(6)~~] (7) "Contractual obligation" means an obligation under any of the following for
764 which coverage is provided under Section 31A-28-103:
765 (a) a policy or contract;
766 (b) a certificate under a group policy or contract; or
767 (c) a portion of a policy or contract.
768 [~~(7)~~] (8) "Coverage date" means the date on which the association becomes responsible
769 for the obligations of a member insurer.
770 [~~(8)~~] (9) "Covered policy" or "covered contract" means any of the following for which
771 coverage is provided in Section 31A-28-103:
772 (a) a policy or contract; or
773 (b) a portion of a policy or contract.
774 [~~(9)~~] (10) (a) "Covered portion" means:
775 (i) for a covered policy that has a cash surrender value, a fraction calculated with:
776 (A) the numerator being the lesser of:
777 (I) (Aa) $200,000 for a life insurance policy; [~~and~~] or
778 (Bb) $250,000 for a covered policy that is not a life insurance policy; or
779 (II) the cash surrender value of the policy; and
780 (B) the denominator being the cash surrender value of the policy; and
781 (ii) for a covered policy that does not have a cash surrender value, a fraction calculated
782 with:
783 (A) the numerator being the lesser of:
784 (I) (Aa) $200,000 for a life insurance policy; [~~or~~] and
785 (Bb) $250,000 for a covered policy that is not a life insurance policy; or

786 (II) the policy's minimum statutory reserve; and
787 (B) the denominator being the policy's minimum statutory reserve.
788 (b) [~~The~~] For purposes of this Subsection (10)(b), the cash surrender value and the
789 minimum statutory reserve are determined as of the coverage date in accordance with the
790 exclusions in Subsection 31A-28-103[~~(2)(b)(iii)~~](7)(c).
791 [~~(10)~~] (11) "Extra-contractual claim" includes a claim relating to:
792 (a) bad faith in the payment of a claim;
793 (b) punitive or exemplary damages; or
794 (c) attorney fees and costs.
795 [~~(11)~~] (12) "Impaired insurer" means a member insurer that is not an insolvent insurer
796 and:
797 (a) is considered by the commissioner to be hazardous pursuant to this title; or
798 (b) is placed under an order of rehabilitation or conservation by a court of competent
799 jurisdiction.
800 [~~(12)~~] (13) "Insolvent insurer" means a member insurer that is placed under an order of
801 liquidation by a court of competent jurisdiction with a finding of insolvency.
802 [~~(13)~~] (14) (a) "Member insurer" means an insurer that holds a certificate of authority
803 to transact in this state any kind of insurance for which coverage is provided under Section
804 31A-28-103.
805 (b) "Member insurer" includes an insurer whose license or certificate of authority in
806 this state may have been:
807 (i) suspended;
808 (ii) revoked;
809 (iii) not renewed; or
810 (iv) voluntarily withdrawn.
811 (c) "Member insurer" does not include:
812 (i) a for-profit or nonprofit:
813 (A) hospital;

814 (B) hospital service organization; or
815 (C) medical service organization;
816 [(ii) a health maintenance organization;]
817 [(iii)] (ii) a fraternal benefit society;
818 [(iv)] (iii) a mandatory state pooling plan;
819 [(v)] (iv) a mutual assessment company or other person that operates on an assessment
820 basis;
821 [(vi)] (v) an insurance exchange;
822 [(vii)] (vi) an organization described in Subsection 31A-22-1305(2); or
823 [(viii)] (vii) an entity similar to an entity described in Subsections [(13)] (14)(c)(i)
824 through [(vii)] (vi).
825 [(14)] (15) "Moody's Corporate Bond Yield Average" means the Monthly Average
826 Corporates as published by Moody's Investors Service, Inc., or any successor to Moody's
827 Investors Service, Inc.
828 [(15)] (16) (a) "Owner" of a policy or contract, "policyholder," "policy owner," or
829 "contract owner" means a person who:
830 (i) is identified as the legal owner under the terms of the policy or contract; or
831 (ii) is otherwise vested with legal title to the policy or contract through a valid
832 assignment:
833 (A) completed in accordance with the terms of the policy or contract; and
834 (B) properly recorded as the owner on the books of the insurer.
835 (b) "Owner," "policyholder," "policy owner," or "contract owner" does not include a
836 person with only a beneficial interest in a policy or contract.
837 [(16) "Person" means:]
838 [(a) an individual;]
839 [(b) a corporation;]
840 [(c) a limited liability company;]
841 [(d) a partnership;]

842 [(e) an association;]
843 [(f) a governmental body or entity;]
844 [(g) a trust; or]
845 [(h) a voluntary organization.]
846 [(17) "Plan sponsor" means:]
847 [(a) the employer, in the case of a benefit plan established or maintained by a single
848 employer;]
849 [(b) the employee organization, in the case of a benefit plan established or maintained
850 by an employee organization; or]
851 [(c) the association, committee, joint board of trustees, or other similar group of
852 representatives of the parties who establish or maintain a benefit plan, in the case of a benefit
853 plan established or maintained by:]
854 [(i) two or more employers; or]
855 [(ii) jointly by:]
856 [(A) one or more employers; and]
857 [(B) one or more employee organizations.]
858 [(18)] (17) (a) ["Premiums"] Notwithstanding Section 31A-1-301, "premiums" means
859 an amount or consideration received on covered policies or contracts, less:
860 (i) returned:
861 (A) premiums;
862 (B) considerations; and
863 (C) deposits; and
864 (ii) dividends and experience credits.
865 (b) (i) "Premiums" does not include an amount or consideration received for:
866 (A) a policy or contract for which coverage is not provided under [Subsection
867 31A-28-103(2)] Subsections 31A-28-103(6) and (7); or
868 (B) the portion of a policy or contract for which coverage is not provided under
869 [Subsection 31A-28-103(2)] Subsections 31A-28-103(6) and (7).

870 (ii) Notwithstanding Subsection [(18)] (17)(b)(i), an assessable premium may not be
871 reduced on account of:
872 (A) Subsection 31A-28-103[(2)(b)(iii)](7)(c) relating to interest limitations; [and] or
873 (B) Subsection 31A-28-103[(3)](8) relating to limitations for:
874 (I) one individual;
875 (II) any one participant; [and] or
876 (III) any one policy or contract owner.
877 (c) "Premiums" does not include premiums in excess of $5,000,000:
878 (i) on an unallocated annuity contract not issued under a governmental retirement plan
879 established under Section 401, 403(b), or 457, Internal Revenue Code; or
880 (ii) for multiple nongroup policies of life insurance owned by one owner:
881 (A) whether the policy or contract owner is an individual, firm, corporation, or other
882 person;
883 (B) whether the persons insured are officers, managers, employees, or other persons;
884 and
885 (C) regardless of the number of policies or contracts held by the owner.
886 [(19)] (18) (a) [Except as provided in Subsection (19)(b), "principal] "Principal place
887 of business" of a plan sponsor or a person other than a natural person means the single state:
888 (i) in which the natural persons who establish policy for the direction, control, and
889 coordination of the operations of the entity as a whole primarily exercise the function; and
890 (ii) determined by the association in its reasonable judgment by considering the
891 following factors:
892 (A) the state in which the primary executive and administrative headquarters of the
893 entity are located;
894 (B) the state in which the principal office of the chief executive officer of the entity is
895 located;
896 (C) the state in which the board of directors, or similar governing person or persons, of
897 the entity conducts the majority of its meetings;

898 (D) the state in which the executive or management committee of the board of
899 directors, or similar governing person, of the entity conducts the majority of its meetings;
900 (E) the state from which the management of the overall operations of the entity is
901 directed; and
902 (F) in the case of a benefit plan sponsored by affiliated companies comprising a
903 consolidated corporation, the state in which the holding company or controlling affiliate has its
904 principal place of business as determined using the factors described in Subsections [(19)]
905 (18)(a)(ii)(A) through (E).
906 (b) Notwithstanding Subsection [(19)] (18)(a), in the case of a plan sponsor, if more
907 than 50% of the participants in the benefit plan are employed in a single state, the state where
908 more than 50% of the participants are employed is considered to be the principal place of
909 business of the plan sponsor.
910 (c) (i) The principal place of business of a plan sponsor of a benefit plan [described in
911 Subsection (3)] is considered to be the principal place of business of the association,
912 committee, joint board of trustees, or other similar group of representatives of the parties who
913 establish or maintain the benefit plan.
914 (ii) If [for a benefit plan described in Subsection (3)] there is not a specific or clear
915 designation of a principal place of business under Subsection [(19)] (18)(c)(i) for a benefit
916 plan, the principal place of business is considered to be the principal place of business of the
917 employer or employee organization that has the largest investment in the benefit plan.
918 [(20)] (19) "Receiver" means, as the context requires:
919 (a) a rehabilitator;
920 (b) a liquidator;
921 (c) an ancillary receiver; or
922 (d) a conservator.
923 [(21)] (20) "Receivership court" means the court in the insolvent or impaired insurer's
924 state having jurisdiction over the conservation, rehabilitation, or liquidation of the member
925 insurer.

926 [(22)] (21) (a) "Resident" means a person:
927 (i) to whom a contractual obligation is owed; and
928 (ii) who resides in this state on the earlier of the date a member insurer is an:
929 (A) impaired insurer; or
930 (B) insolvent insurer.
931 (b) A person may be a resident of only one state, which in the case of a person other
932 than a natural person is where its principal place of business is located.
933 (c) A citizen of the United States that is either a resident of a foreign country or a
934 resident of a United States possession, territory, or protectorate that does not have an
935 association similar to the association created by this part, is considered a resident of the state of
936 domicile of the member insurer that issued the policy or contract.
937 [(23) "State" means:]
938 [(a) a state;]
939 [(b) the District of Columbia;]
940 [(c) Puerto Rico; and]
941 [(d) a United States possession, territory, or protectorate.]
942 [(24)] (22) "Structured settlement annuity" means an annuity purchased to fund
943 periodic payments for a plaintiff or other claimant in payment for personal injury suffered by
944 the plaintiff or other claimant.
945 (23) "Structured settlement factoring transaction" means the same as that term is
946 defined in 26 U.S.C. Sec. 5891(c)(3)(A).
947 [(25)] (24) "Supplemental contract" means a written agreement entered into for the
948 distribution of proceeds under a policy or contract for:
949 (a) life insurance;
950 (b) accident and health insurance; or
951 (c) annuity.
952 [(26)] (25) "Unallocated annuity contract" means an annuity contract or group annuity
953 certificate that is not issued to and owned by an individual, except to the extent of any annuity

954 benefits guaranteed to an individual by an insurer under the contract or certificate.

955 Section 8. Section **31A-28-106** is amended to read:

956 **31A-28-106. Continuation of the association -- Association duties -- Allocation of**
957 **assessments -- Not agency of state.**

958 (1) (a) There is continued under this part the nonprofit legal entity known as the Utah
959 Life and Health Insurance Guaranty Association created under former provisions of this title.

960 (b) All member insurers shall be and remain members of the association as a condition
961 of their authority to transact insurance in this state.

962 (c) The association shall:

963 (i) perform its functions under the plan of operation established and approved under
964 Section 31A-28-110; and

965 (ii) exercise [~~its~~] the association's powers through [~~a~~] the board of directors
966 [~~established under Section 31A-28-107~~].

967 (d) The association shall allocate assessments among the following classes or
968 subclasses:

969 (i) the life insurance and annuity class, which includes the following subclasses:

970 (A) the life insurance subclass;

971 (B) the annuity subclass:

972 (I) which includes annuity contracts owned by a governmental retirement plan, or its
973 trustee, established under Section 401, 403(b), or 457, Internal Revenue Code; and

974 (II) otherwise excludes unallocated annuities; and

975 (C) the unallocated annuity subclass, which excludes contracts owned by a
976 governmental retirement benefit plan, or its trustee, established under Sections 401, 403(b), or
977 457, Internal Revenue Code; and

978 (ii) the accident and health insurance class.

979 (2) (a) The association shall:

980 (i) come under the immediate supervision of the commissioner; and

981 (ii) be subject to the applicable provisions of the insurance laws of this state.

982 (b) Meetings or records of the association may be opened to the public upon majority
983 vote of the board of directors [~~of the association~~].
984 (3) The association is not an agency of the state.
985 Section 9. Section **31A-28-107** is amended to read:
986 **31A-28-107. Board of directors.**
987 (1) (a) The board of directors of the association shall consist of:
988 (i) at least [~~five~~] seven but not more than [~~nine~~] eleven member insurers who:
989 (A) [~~subject to Subsection (1)(c),~~] serve terms as established in the plan of operation;
990 and
991 (B) are selected by member insurers, subject to the approval of the commissioner; and
992 (ii) two public representatives appointed by the commissioner.
993 (b) (i) The commissioner shall make the appointment of a public representative
994 coincide with the association's annual meeting at which the association's board of directors is
995 elected.
996 (ii) A public representative may not be:
997 (A) an officer, director, or employee of an insurer; or
998 (B) a person engaged in the business of insurance.
999 (iii) [~~Subject to Subsection (1)(c), a~~] A public representative shall serve a term of three
1000 years.
1001 (c) When a vacancy occurs in the membership of the board of directors for any reason:
1002 (i) if the vacancy is of a member insurer, a replacement may be elected for the
1003 unexpired term by a majority vote of the remaining board members, subject to the approval of
1004 the commissioner; and
1005 (ii) if the vacancy is of a public representative, the commissioner shall appoint a
1006 replacement for the unexpired term.
1007 (d) In approving a selection or in appointing a member to the board of directors, the
1008 commissioner shall consider, among other things, whether all member insurers are fairly
1009 represented.

1010 (e) Notwithstanding Subsections (1)(a) and (b), the commissioner shall, at the time of
1011 election, reelection, appointment, or reappointment adjust the length of terms to ensure that the
1012 terms of board members are staggered so that approximately half of the board of directors is
1013 selected during any two-year period.
1014 (2) (a) A member of the board of directors may be reimbursed from the assets of the
1015 association for expenses incurred by the member as a member of the board of directors.
1016 (b) A public representative appointed under Subsection (1)(a)(ii) may not receive
1017 compensation or benefits for the public representative's service, but in addition to
1018 reimbursement under Subsection (2)(a), a public representative may receive per diem and
1019 travel expenses established by the board with the approval of the commissioner.
1020 (c) Except as provided in Subsections (2)(a) and (b), a member of the board of
1021 directors may not be compensated by the association for the member's services.
1022 Section 10. Section **31A-28-108** is amended to read:
1023 **31A-28-108. Powers and duties of the association.**
1024 (1) (a) If a member insurer is an impaired insurer, subject to any conditions imposed by
1025 the association that do not impair the contractual obligations of the impaired insurer, the
1026 association may provide the protections provided by this part.
1027 (b) If the association makes the election described in Subsection (1)(a), the association
1028 may proceed under one or more of the options described in Subsection (3).
1029 (2) If a member insurer is an insolvent insurer, the association shall provide the
1030 protections provided by this part by electing in its discretion to proceed under one or more of
1031 the options in Subsection (3).
1032 (3) With respect to the covered portions of covered policies of an [~~impaired or~~]
1033 insolvent insurer, the association may:
1034 (a) (i) (A) guaranty, assume, reissue, or reinsure, or cause to be guaranteed, assumed,
1035 reissued, or reinsured, the policies or contracts of the insolvent insurer; or
1036 (B) assure payment of the contractual obligations of the insolvent insurer; and
1037 (ii) provide the money, pledges, loans, notes, guarantees, or other means as are

1038 reasonably necessary to discharge such duties; or
1039 (b) provide benefits and coverages in accordance with Subsection (4).
1040 (4) (a) [~~In accordance with Subsection (3)(b), the~~] The association may proceed under
1041 Subsection (3)(b) by:
1042 (i) [~~assure~~] ensuring payment of benefits [~~for premiums identical to the premiums and~~
1043 ~~benefits, except for terms of conversion and renewability,~~] that would have been payable under
1044 the policies or contracts of the insurer, for claims incurred:
1045 (A) with respect to group policies or contracts:
1046 (I) not later than the earlier of the next renewal date under the policies or contracts or
1047 45 days after the coverage date; and
1048 (II) in no event less than 30 days after the coverage date; or
1049 (B) with respect to nongroup policies or contracts:
1050 (I) not later than the earlier of the next renewal date, if any, under the policies or
1051 contracts or one year from the coverage date; and
1052 (II) in no event less than 30 days from the coverage date;
1053 (ii) [~~make~~] making diligent efforts to notify the following 30 days before any
1054 termination of the benefits that are provided under a policy or contract of the insurer:
1055 (A) the known insureds, enrollees, or annuitants for nongroup policies and contracts;
1056 (B) owners if other than an insured, enrollee, or annuitant; or
1057 (C) group policy or contract owners for group policies and contracts; and
1058 (iii) with respect to nongroup [~~life and accident and health insurance policies and~~
1059 ~~annuities, make~~] policies and contracts, making available substitute coverage on an individual
1060 basis, in accordance with Subsection (4)(b), to each known insured, enrollee, annuitant, or
1061 owner and to each individual formerly an insured, enrollee, or [~~formerly an~~] annuitant under a
1062 group policy or contract who is not eligible for replacement group coverage on an individual
1063 basis in accordance with Subsection (4)(b), if the insured, enrollee, or annuitant had a right
1064 under law or the terminated policy, contract, or annuity [~~contract~~] to:
1065 (A) convert coverage to individual coverage; or

1066 (B) continue an individual policy or contract in force until a specified age or for a
1067 specified time during which the insurer had:
1068 (I) no right unilaterally to make changes in any provision of the policy or contract; or
1069 (II) a right only to make changes in premium by class of risk.
1070 (b) (i) In providing the substitute coverage required under Subsection (4)(a)(iii), the
1071 association may offer to:
1072 (A) reissue the terminated coverage; or
1073 (B) issue an alternative policy or contract at actuarially justified rates.
1074 (ii) An alternative or reissued policy or contract under Subsection (4)(b)(i):
1075 (A) shall be offered without requiring evidence of insurability; and
1076 (B) may not provide for any waiting period or exclusion that would not have applied
1077 under the terminated policy or contract.
1078 (iii) The association may reinsure an alternative or reissued policy or contract.
1079 (c) (i) An alternative policy or contract adopted by the association is subject to the
1080 approval of the commissioner.
1081 (ii) The association may adopt alternative policies or contracts of various types for
1082 future issuance without regard to any particular impairment or insolvency.
1083 (iii) An alternative policy or contract:
1084 (A) shall contain at least the minimum statutory provisions required in this state; and
1085 (B) provide benefits that are not unreasonable in relation to the premium charged.
1086 (iv) The association shall set the premium for an alternative policy or contract in
1087 accordance with a table of rates that the association adopts.
1088 (v) The premium described in Subsection (4)(c)(iv) shall reflect:
1089 (A) the amount of insurance or coverage to be provided; and
1090 (B) the age and class of risk of each insured.
1091 [~~(v)~~] (vi) For an alternative policy or contract issued under an individual policy or
1092 contract of the impaired or insolvent insurer:
1093 (A) age shall be determined in accordance with the original policy or contract

1094 provisions; and

1095 (B) class of risk is the class of risk under the original policy or contract.

1096 [(vi)] (vii) For an alternative policy or contract issued to individuals insured or covered

1097 under a group policy or contract:

1098 (A) age and class of risk shall be determined by the association in accordance with the

1099 alternative policy or contract provisions and risk classification standards approved by the

1100 commissioner; and

1101 (B) the premium may not reflect any changes in the health of the insured after the

1102 original policy or contract was last underwritten.

1103 [(vii)] (viii) An alternative policy or contract issued by the association shall provide

1104 coverage of a type similar to that of the policy or contract issued by the impaired or insolvent

1105 insurer, as determined by the association.

1106 (d) If the association elects to reissue terminated coverage at a premium rate different

1107 from that charged under the terminated policy or contract, the association shall set the premium

1108 in a manner that is actuarially justified and in accordance with the amount of insurance or

1109 coverage provided and the age and class of risk, subject to the prior approval of the

1110 commissioner or by a court of competent jurisdiction.

1111 (e) The association's obligations with respect to coverage under any policy or contract

1112 of the impaired or insolvent insurer or under any reissued or alternative policy or contract

1113 ceases on the date the coverage [or], policy, or contract is replaced by another similar coverage,

1114 policy, or contract by:

1115 (i) the enrollee;

1116 (ii) the owner;

1117 [(ii)] (iii) the insured; or

1118 [(iii)] (iv) the association.

1119 (f) (i) With respect to a claim unpaid as of the coverage date and [a] an accident and

1120 health claim incurred during the period defined in Subsection (4)(a)(i), a provider of health care

1121 services, by accepting a payment from the association upon a claim of the provider against an

1122 insured or enrollee whose [health care] insurer is an insolvent [member] insurer, agrees to
1123 forgive the insured or enrollee of 20% of the debt [which] that otherwise would be paid by the
1124 insolvent insurer had [it] the insurer not been insolvent[, subject to a maximum of $8,000 being
1125 required to be forgiven by any one provider as to each claimant].
1126 (ii) The obligations of a solvent insurer to pay all or part of the covered claim are not
1127 diminished by the forgiveness provided for in this section.
1128 (5) When proceeding under Subsection (3)(b) with respect to any policy or contract
1129 carrying guaranteed minimum interest rates, the association shall assure the payment or
1130 crediting of a rate of interest consistent with Subsection 31A-28-103[(2)(b)(iii)](7)(c).
1131 (6) Nonpayment of premiums within 31 days after the date required under the terms of
1132 any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage
1133 terminates the association's obligations under the policy, contract, or coverage under this part
1134 with respect to the policy, contract, or coverage, except with respect to any claims incurred or
1135 any net cash surrender value that may be due in accordance with this part.
1136 (7) (a) Premium due after the coverage date with respect to the covered portion of a
1137 policy or contract of an impaired or insolvent insurer belongs to and is payable at the direction
1138 of the association. If a liquidator of an insolvent insurer requests the report, the association
1139 shall report to the liquidator the premium collected by the association.
1140 (b) The association is liable to a policy or contract owner for unearned premiums due
1141 to the policy or contract owner arising after the coverage date with respect to the covered
1142 portion of the policy or contract.
1143 (8) The protection provided by this part does not apply if any guaranty protection is
1144 provided to residents of this state by laws of the domiciliary state or jurisdiction of the
1145 impaired or insolvent insurer other than this state.
1146 (9) In carrying out its duties under Subsection (2), and subject to approval by a court in
1147 this state, the association may:
1148 (a) impose permanent policy or contract liens in connection with a guarantee,
1149 assumption, or reinsurance agreement, if the association finds that:

1150 (i) the amounts that can be assessed under this part are less than the amounts needed to
1151 assure full and prompt performance of the association's duties under this part; or
1152 (ii) the economic or financial conditions as they affect member insurers are sufficiently
1153 adverse to render the imposition of the permanent policy or contract liens to be in the public
1154 interest;
1155 (b) impose temporary moratoriums or liens on payments of cash values and policy
1156 loans, or any other right to withdraw funds held in conjunction with policies or contracts, in
1157 addition to any contractual provisions for deferral of cash or policy loan value; and
1158 (c) if the receivership court imposes a temporary moratorium or moratorium charge on
1159 payment of cash values or policy loans, or on any other right to withdraw funds held in
1160 conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer,
1161 defer the payment of cash values, policy loans, or other rights by the association for the period
1162 of the moratorium or moratorium charge imposed by the receivership court, except for claims
1163 covered by the association to be paid in accordance with a hardship procedure:
1164 (i) established by the receiver; and
1165 (ii) approved by the receivership court.
1166 (10) (a) A special deposit in this state held pursuant to law or required by the
1167 commissioner for the benefit of creditors, including policy or contract owners, that is not
1168 turned over to the domiciliary receiver upon the entry of a final order of liquidation or order
1169 approving a rehabilitation plan of [~~an~~] a member insurer domiciled in any state shall be
1170 promptly paid to the association.
1171 (b) Any amount paid under Subsection (10)(a) to the association less the amount
1172 retained by the association shall be treated as a distribution of estate assets pursuant to Sections
1173 31A-27a-601, 31A-27a-602, and 31A-27a-701.
1174 (11) If the association fails to act within a reasonable period of time as provided in this
1175 section, the commissioner has the powers and duties of the association under this part with
1176 respect to an impaired or insolvent insurer.
1177 (12) The association may assist or advise the commissioner, upon the commissioner's

1178 request, concerning:
1179 (a) rehabilitation;
1180 (b) payment of claims;
1181 (c) continuance of coverage; or
1182 (d) the performance of other contractual obligations of any impaired or insolvent
1183 insurer.
1184 (13) (a) The association has standing to appear or intervene before a court or agency in
1185 this state with jurisdiction over:
1186 (i) an impaired or insolvent insurer concerning which the association is or may become
1187 obligated under this part; or
1188 (ii) any person or property against which the association may have rights through
1189 subrogation or otherwise.
1190 (b) The standing referred to in Subsection (13)(a) extends to all matters germane to the
1191 powers and duties of the association, including:
1192 (i) proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or
1193 contracts of the impaired or insolvent insurer; and
1194 (ii) the determination of the policies or contracts and contractual obligations.
1195 (c) The association has the right to appear or intervene before a court in another state
1196 with jurisdiction over:
1197 (i) an impaired or insolvent insurer for which the association is or may become
1198 obligated; or
1199 (ii) any person or property against which the association may have rights through
1200 subrogation of the insurer's [~~policyowners~~] policy owners or contract owners.
1201 (14) (a) A person receiving benefits under this part is considered to have assigned the
1202 rights under, and any causes of action against any person for losses arising under, resulting
1203 from, or otherwise relating to the covered policy or contract to the association to the extent of
1204 the benefits received because of this part, whether the benefits are payments of, or on account
1205 of:

1206 (i) contractual obligations;
1207 (ii) continuation of coverage; or
1208 (iii) provision of substitute or alternative policies, contracts, or coverages.
1209 (b) As a condition precedent to the receipt of any right or benefits conferred by this part
1210 upon that person, the association may require an assignment to it of the rights and causes of
1211 action described in Subsection (14)(a) by any:
1212 (i) payee;
1213 (ii) policy or contract owner;
1214 (iii) beneficiary;
1215 (iv) insured; [~~or~~]
1216 (v) enrollee; or
1217 [~~(v)~~] (vi) annuitant.
1218 (c) The subrogation rights obtained by the association under this Subsection (14) have
1219 the same priority against the assets of the impaired or insolvent insurer as that possessed by the
1220 person entitled to receive benefits under this part.
1221 (d) In addition to Subsections (14)(a) through (c), the association has the common law
1222 rights of subrogation and any other equitable or legal remedy that would have been available to
1223 the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or
1224 contract with respect to the policy or contract, including in the case of a structured settlement
1225 annuity any rights of the owner, beneficiary, or payee of the annuity to the extent of benefits
1226 received pursuant to this part against a person originally or by succession responsible for the
1227 losses arising from the personal injury relating to the annuity or payment of the annuity.
1228 (e) If a provision of this Subsection (14) is invalid or ineffective with respect to a
1229 person or claim for any reason, the amount payable by the association with respect to the
1230 related covered obligations shall be reduced by the amount realized by any other person with
1231 respect to the person or claim that is attributable to the policies, or portion of the policies,
1232 covered by the association.
1233 (f) If the association has provided benefits with respect to a covered policy or contract

1234 and a person recovers amounts as to which the association has rights as described in this
1235 Subsection (14), the person shall pay to the association the portion of the recovery attributable
1236 to the covered [~~policies~~] policy or contract.
1237 (15) (a) In addition to the rights and powers elsewhere in this part, the association may:
1238 (i) enter into a contract that is necessary or proper to carry out the provisions and
1239 purposes of this part;
1240 (ii) sue or be sued, including taking any legal actions necessary or proper to:
1241 (A) recover any unpaid assessments under Section 31A-28-109; and
1242 (B) settle claims or potential claims against the association;
1243 (iii) borrow money to effect the purposes of this part;
1244 (iv) employ or retain the persons necessary or the appropriate staff members to:
1245 (A) handle the financial transactions of the association; and
1246 (B) perform other functions as become necessary or proper under this part;
1247 (v) take necessary or appropriate legal action to avoid or recover payment of improper
1248 claims;
1249 (vi) exercise, for the purposes of this part and to the extent approved by the
1250 commissioner, the powers of a domestic [~~life or health~~] insurer providing life insurance or
1251 accident and health insurance, but in no case may the association issue [~~insurance~~] policies or
1252 [~~annuity~~] contracts other than those issued to perform [~~its~~] the association's obligation under
1253 this part;
1254 (vii) request information from a person seeking coverage from the association to aid
1255 the association in determining the association's obligations under this part with respect to the
1256 person;
1257 (viii) unless prohibited by law, in accordance with the terms and conditions of the
1258 policy or contract, file for actuarially justified rate or premium increases for any policy or
1259 contract for which the association provides coverage under this part;
1260 [~~(viii)~~] (ix) take other necessary or appropriate action to discharge the association's
1261 duties and obligations under this part or to exercise the association's powers under this part;

1262 and

1263 [~~(ix)~~] (x) act as a special deputy receiver if appointed by the commissioner.

1264 (b) Any note or other evidence of indebtedness of the association under Subsection

1265 (15)(a)(iii) that is not in default:

1266 (i) is a legal investment for a domestic member insurer; and

1267 (ii) may be carried as admitted assets.

1268 (c) A person seeking coverage from the association shall promptly comply with a

1269 request for information by the association under Subsection (15)(a)(vii).

1270 (16) The association may join an organization of one or more other state associations

1271 of similar purposes to further the purposes and administer the powers and duties of the

1272 association.

1273 (17) (a) At any time within 180 days after the coverage date, the association may elect

1274 to succeed to the rights and obligations of the member insurer that:

1275 (i) accrue on or after the coverage date; and

1276 (ii) relate to covered policies or contracts under any one or more indemnity reinsurance

1277 agreements:

1278 (A) entered into by the member insurer as a ceding insurer and its reinsurer; and

1279 (B) selected by the association.

1280 (b) An election made pursuant to Subsection (17)(a) is effective as of the date of the

1281 order of liquidation.

1282 (c) The association may make an election described in Subsection (17)(a) by notifying

1283 an affected reinsurer in writing, with verification of receipt, through:

1284 (i) the association; or

1285 (ii) a nationally recognized association representing state guaranty associations that is

1286 approved by the commissioner, that provides notice on behalf of the association.

1287 (d) The association shall provide a copy of the notice described in Subsection (17)(c) to

1288 the receiver.

1289 (e) (i) The receiver of an insolvent insurer and each reinsurer of the ceding member

1290 insurers shall make available as soon as possible after commencement of formal delinquency
1291 proceedings the information described in Subsection (17)(e)(ii) to:
1292 (A) the association; or
1293 (B) a nationally recognized association representing state guaranty associations that is
1294 approved by the commissioner, on behalf of the association.
1295 (ii) This Subsection (17)(e) applies to:
1296 (A) copies of in-force contracts of reinsurance and the related records relevant to the
1297 determination of whether the in-force contracts of reinsurance should be assumed;
1298 (B) notices of any default under a reinsurance contract; or
1299 (C) any known event or condition that with the passage of time could become a default
1300 under a reinsurance contract.
1301 (f) If the association makes an election under Subsection (17)(a), the association shall
1302 comply with Subsections (17)(f)(i) through (vii) with respect to the agreements selected by the
1303 association.
1304 (i) For a policy or contract covered, in whole or in part, by the association, the
1305 association is responsible for:
1306 (A) the unpaid premiums due under the agreements for periods both before and after
1307 the coverage date; and
1308 (B) the performance of the other obligations to be performed after the coverage date.
1309 (ii) The association may charge a policy or contract covered in part by the association
1310 the costs for reinsurance in excess of the obligations of the association, through reasonable
1311 allocation methods.
1312 (iii) The association shall provide notice and an accounting to the receiver of a charge
1313 made pursuant to Subsection (17)(f)(ii).
1314 (iv) The association is entitled to any amounts payable by the reinsurer under the
1315 agreements with respect to a loss or event that:
1316 (A) occurs after the coverage date; and
1317 (B) relates to a policy or a contract covered by the association, in whole or in part.

1318 (v) On receipt of any amounts under Subsection (17)(f)(iv), the association shall pay to
1319 the beneficiary under the policy or contract on account of which the amounts were paid an
1320 amount equal to the lesser of:
1321 (A) the amount received by the association; and
1322 (B) the excess of the amount received by the association over the benefits paid or
1323 payable by the association on account of the policy or contract less the retention of the insurer
1324 applicable to the loss or event.
1325 (vi) (A) Within 30 days following the association's election, the association and each
1326 indemnity reinsurer shall calculate the net balance due to or from the association under each
1327 reinsurance agreement as of the date of the association's election, giving full credit to the items
1328 paid by either the member insurer, its receiver, or the indemnity reinsurer before the date of the
1329 association's election.
1330 (B) Within five days of the completion of the calculation under Subsection
1331 (17)(f)(vi)(A):
1332 (I) the reinsurer shall pay the receiver the amounts due for a loss or event before the
1333 coverage date, subject to any set-off for premiums unpaid for a period before the coverage date;
1334 and
1335 (II) the association or the reinsurer shall pay any remaining balance due the other.
1336 (C) A dispute over an amount due to either party shall be resolved:
1337 (I) by arbitration pursuant to the terms of the affected reinsurance contract; or
1338 (II) if the reinsurance contract contains no arbitration clause, as otherwise provided by
1339 law.
1340 (D) If the receiver receives an amount due the association pursuant to Subsection
1341 (17)(f)(iv), the receiver shall remit that amount to the association as promptly as practicable.
1342 (vii) If the association, or the receiver on behalf of the association, within 60 days of
1343 the election, pays the premiums due for periods both before and after the coverage date that
1344 relate to <u>policies or</u> contracts covered by the association, in whole or in part, the reinsurer may
1345 not:

1346 (A) terminate the reinsurance agreement for failure to pay premium, to the extent the
1347 reinsurance agreement relates to a policy or contract covered by the association, in whole or in
1348 part; and
1349 (B) set off against amounts due the association an amount due:
1350 (I) under another policy or contract; or
1351 (II) as an unpaid amount due from a person other than the association.
1352 (g) (i) This Subsection (17)(g) applies during the period that:
1353 (A) begins on the coverage date; and
1354 (B) ends:
1355 (I) on the election date; or
1356 (II) if no election date occurs, 180 days after the coverage date.
1357 (ii) During the period described in Subsection (17)(g)(i):
1358 (A) neither the association nor the reinsurer have a right or obligation under a
1359 reinsurance contract that the association may assume under Subsection (17)(a), whether for a
1360 period before or after the coverage date; and
1361 (B) the reinsurer, the receiver, and the association, to the extent practicable, shall
1362 provide each other data and records reasonably requested.
1363 (iii) Notwithstanding Subsection (17)(g)(ii), once the association elects to assume a
1364 reinsurance contract, the parties' rights and obligations are governed by Subsections (17)(f)(i)
1365 through (vi).
1366 (h) If the association does not elect to assume a reinsurance contract by the election
1367 date pursuant to Subsection (17)(a), the association has no right or obligation with respect to
1368 the reinsurance contract, whether for a period before or after the coverage date.
1369 (i) An insurer other than the association succeeds to the rights and obligations of the
1370 association under Subsections (17)(a) through (f) effective as of the date agreed upon by the
1371 association and the other insurer and regardless of whether the association has made the
1372 election referred to in Subsections (17)(a) through (f) provided that:
1373 (i) the association transfers its obligations to the other insurer;

1374 (ii) the association and the other insurer agree to the transfer;
1375 (iii) the indemnity reinsurance agreements automatically terminate for new reinsurance
1376 unless the indemnity reinsurer and the other insurer agree to the contrary;
1377 (iv) the obligations described in Subsection (17)(f)(v) may not apply on and after the
1378 date the indemnity reinsurance agreement is transferred to the third party insurer;
1379 (v) the transferring party shall give notice in writing, with verification of receipt, to the
1380 affected reinsurer not less than 30 days before the effective date of the transfer; and
1381 (vi) this Subsection (17)(i) may not apply if the association has previously expressly
1382 determined in writing that the association will not exercise the election referred to in
1383 Subsections (17)(a) through (f).
1384 (j) (i) This Subsection (17) supersedes the provisions of any law of this state or of any
1385 affected reinsurance agreement that provides for or requires any payment of reinsurance
1386 proceeds on account of losses or events that occur in periods after the coverage date, to:
1387 (A) the receiver of an insolvent member insurer; or
1388 (B) another person.
1389 (ii) The receiver is entitled to any amounts payable by the reinsurer under the
1390 reinsurance agreement with respect to a loss or event that occurs before the coverage date,
1391 subject to applicable setoff provisions.
1392 (k) Except as otherwise expressly provided in Subsections (17)(a) through (j), this
1393 Subsection (17) does not:
1394 (i) alter or modify the terms and conditions of a reinsurance agreement of the insolvent
1395 member insurer;
1396 (ii) abrogate or limit a right any reinsurer to claim that it is entitled to rescind a
1397 reinsurance agreement;
1398 (iii) give a policy owner, policy holder, contract owner, enrollee, certificate holder, or
1399 beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in
1400 the reinsurance agreement;
1401 (iv) limit or affect the association's rights as a creditor of the estate of an insolvent

1402 insurer against the assets of the estate; or

1403 (v) apply to a reinsurance agreement that covers property or casualty risks.

1404 (18) The board of directors of the association has discretion and may exercise

1405 reasonable business judgment to determine the means by which the association is to provide

1406 the benefits of this part in an economical and efficient manner.

1407 (19) If the association arranges or offers to provide the benefits of this part to a covered

1408 person under a plan or arrangement that fulfills the association's obligations under this part, the

1409 person is not entitled to benefits from the association in addition to or other than those

1410 provided under the plan or arrangement.

1411 (20) (a) Venue in a suit against the association arising under this part is Salt Lake

1412 County.

1413 (b) The association may not be required to give an appeal bond in an appeal that relates

1414 to a cause of action arising under this part.

1415 Section 11. Section **31A-28-109** is amended to read:

1416 **31A-28-109. Assessments.**

1417 (1) (a) For the purpose of providing the funds necessary to carry out the powers and

1418 duties of the association, the board of directors shall assess the member insurers, separately for

1419 each class or subclass, at the time and for the amounts that the board of directors finds

1420 necessary.

1421 (b) Member insurer liability for an assessment is established [~~as of~~] beginning on the

1422 coverage date, regardless of when the assessment is called.

1423 (c) [~~Subject to Subsection (1)(d), a~~] A called assessment:

1424 (i) is due not less than 30 days after prior written notice to the member insurer; and

1425 (ii) shall accrue interest at 10% per annum on and after the due date.

1426 (d) Notwithstanding Subsection (1)(c), the association may:

1427 (i) assess the association's members as of the coverage date; and

1428 (ii) defer the collection of the assessment described in Subsection (1)(d)(i).

1429 (e) An assessment:

1430 (i) has the force and effect of a judgment lien against the member insurer; and
1431 (ii) may not be extinguished until paid.
1432 (2) [~~The~~] There are two classes of [~~assessment are described in Subsections (2)(a) and~~
1433 ~~(2)(b).~~] assessments:
1434 (a) [~~A~~] a Class A assessment [~~shall be~~]:
1435 (i) shall be authorized and called for the purpose of meeting administrative and legal
1436 costs and other expenses[~~. A Class A assessment~~]; and
1437 (ii) may be authorized and called regardless of whether [~~or not~~] the assessment is
1438 related to a particular impaired or insolvent insurer[~~.~~]; and
1439 (b) [~~A~~] a Class B assessment shall be authorized and called to the extent necessary to
1440 carry out the powers and duties of the association under Section 31A-28-108 with regard to an
1441 impaired or an insolvent insurer.
1442 (3) (a) (i) The amount of a Class A assessment:
1443 (A) shall be determined by the board of directors; and
1444 (B) may be authorized and called on a pro rata or non-pro rata basis.
1445 (ii) If the Class A assessment is pro rata, the board of directors may credit the
1446 assessment against future Class B assessments.
1447 [~~(iii) The total of the non-pro rata assessments may not exceed $300 per member~~
1448 ~~insurer in any one calendar year.~~]
1449 (b) (i) [~~The~~] Except as provided in Subsection (3)(c)(i), the amount of a Class B
1450 assessment shall be allocated for assessment purposes [~~among subclasses~~]:
1451 (A) between the life insurance and annuity class and the accident and health insurance
1452 class; and
1453 (B) among the subclasses of the life insurance and annuity class.
1454 (ii) An allocation of a Class B assessment under Subsection (3)(b)(i) shall be made
1455 pursuant to an allocation formula that may be based on:
1456 [~~(i)~~] (A) the premiums or reserves of the impaired or insolvent insurer; or
1457 [~~(ii)~~] (B) any other standard determined by the board of directors in the board of

1458 directors' sole discretion as being fair and reasonable under the circumstances.
1459 (c) (i) For a Class B assessment for the long-term care insurance written by an impaired
1460 or insolvent insurer, the association:
1461 (A) shall, except as prohibited in Subsection (3)(c)(i)(B), allocate the amount of the
1462 Class B assessment according to a methodology that provides for 25% of the assessment to be
1463 allocated to accident and health member insurers and 75% of the assessment to be allocated to
1464 life insurance and annuity member insurers;
1465 (B) may not impose liability on a member insurer that is a health maintenance
1466 organization for an assessment with a coverage date before January 1, 2021;
1467 (C) may not consider the premiums from a health maintenance organization contract
1468 when calculating the share of an assessment with a coverage date before January 1, 2021,
1469 allocated to accident and health member insurers; and
1470 (D) shall include the methodology described in Subsection (3)(c)(i)(A) in the plan of
1471 operation established and approved under Section 31A-28-110.
1472 [(c) (i)] (ii) A Class B assessment against a member insurer for the life insurance
1473 subclass, the annuity subclass, and the unallocated annuity subclass shall be in the proportion
1474 that the premiums received on business in [this] the state by the member insurer on policies or
1475 contracts included in the class or subclass for the three most recent calendar years for which
1476 information is available preceding the year which includes the coverage date bears to the
1477 premiums received on business in [this state for] the state during the same three-calendar-year
1478 period by [the] all assessed member insurers on policies or contracts included in the class or
1479 subclass.
1480 [(ii)] (iii) A Class B assessment against a member insurer for an accident and health
1481 insurance [subclass] class shall be in the proportion that the premiums received on business in
1482 [this] the state by each assessed member insurer on policies or contracts included in the
1483 [subclass] class for the most recent calendar year for which information is available preceding
1484 the year in which the assessment is made bears to the premiums received on business in this
1485 state on policies or contracts included in the [subclass] class for that calendar year by [the] all

1486 assessed member insurers.

1487 (d) Assessments for funds to meet the requirements of the association with respect to
1488 an impaired or insolvent insurer may not be authorized or called until necessary to implement
1489 the purposes of this part.

1490 (e) Classification and computation of assessments and premiums [under Subsection
1491 (3)(b) and computation of assessments under this Subsection (3)] under this section shall be
1492 made with a reasonable degree of accuracy, recognizing that exact determinations may not
1493 always be possible.

1494 (f) The association shall notify each member insurer of [its] the member insurer's
1495 anticipated pro rata share of an authorized assessment not yet called within 180 days after the
1496 day on which the assessment is authorized.

1497 (4) (a) The association may abate or defer, in whole or in part, the assessment of a
1498 member insurer if, in the opinion of the board of directors, payment of the assessment would
1499 endanger the ability of the member insurer to fulfill its contractual obligations.

1500 (b) If an assessment against a member insurer is abated or deferred in whole or in part
1501 under Subsection (4)(a), the amount by which the assessment is abated or deferred may be
1502 assessed against the other member insurers in a manner consistent with the basis for
1503 assessments set forth in this section.

1504 (c) Once a condition that caused a deferral is removed or rectified, the member insurer
1505 shall pay the assessments that were deferred pursuant to a repayment plan approved by the
1506 association.

1507 (5) (a) (i) Subject to Subsection (5)(b), the total of the assessments authorized by the
1508 association on a member insurer for each class or subclass may not in any one calendar year
1509 exceed 2% of [that member's total] the member insurer's average annual assessable premium in
1510 that class or subclass as defined in Subsection (3).

1511 (ii) If two or more assessments are authorized in one calendar year with respect to
1512 [one] two or more member insurers that become impaired or insolvent in different calendar
1513 years, the average annual assessable premiums for purposes of the aggregate assessment

1514 percentage limitation [in] calculated for each subclass or class under Subsection (5)(a)(i) shall
1515 be equal and limited to the highest of the total average annual assessable [premiums of]
1516 premium averages for the different calendar year periods involved in the assessment or
1517 assessments.
1518 (iii) If the maximum assessment together with the other assets of the association do not
1519 provide in one year an amount sufficient to carry out the responsibilities of the association, the
1520 necessary additional funds shall be assessed as soon after as permitted by this part.
1521 (b) The board of directors may provide in the plan of operation a method of allocating
1522 funds among claims, whether relating to one or more impaired or insolvent insurers, when the
1523 maximum assessment will be insufficient to cover anticipated claims.
1524 (c) If the maximum assessment for the life insurance subclass or the annuity subclass in
1525 any one year does not provide an amount sufficient to carry out the responsibilities of the
1526 association, the board of directors shall assess the other of the subclasses of the life insurance
1527 and annuity class for the necessary additional amount:
1528 (i) pursuant to Subsection (3)(b); and
1529 (ii) subject to the maximum stated in Subsection (5)(a).
1530 (6) (a) The board of directors may, by an equitable method established in the plan of
1531 operation, refund to member insurers in proportion to the contribution of each member insurer
1532 to that subclass the amount by which the assets of the subclass exceed the amount the board of
1533 directors finds is necessary to carry out the obligations of the association with regard to that
1534 subclass, including assets accruing from:
1535 (i) assignment;
1536 (ii) subrogation;
1537 (iii) net realized gains; and
1538 (iv) income from investments.
1539 (b) Notwithstanding Subsection (6)(a), a reasonable amount may be retained to provide
1540 funds for the continuing expenses of the association and for future losses.
1541 (7) A member insurer, in determining its premium rates and policyowner dividends as

1542 to any kind of insurance within the scope of this part, may consider the amount reasonably
1543 necessary to meet its assessment obligations under this part.
1544 (8) (a) The association shall issue to each member insurer paying an assessment under
1545 this part, other than a Class A assessment, a certificate of contribution, in a form approved by
1546 the commissioner, for the amount of the assessment paid.
1547 (b) The outstanding certificates described in Subsection (8)(a) shall be of equal dignity
1548 and priority without reference to amounts or dates of issue.
1549 (c) (i) A certificate of contribution described in Subsection (8)(a) may be shown by the
1550 member insurer in its financial statement as an asset in the amount of the certificate of
1551 contribution less the amount by which the insurer's premium taxes have already been reduced
1552 with respect to the certificate.
1553 (ii) For good cause shown, the commissioner may order the insurer to show a different
1554 amount in its financial statement than the amount under Subsection (8)(c)(i).
1555 (9) (a) (i) A member insurer that wishes to protest all or part of an assessment shall
1556 pay, when due, the full amount of the assessment as specified in the notice provided by the
1557 association.
1558 (ii) The payment shall be available to meet association obligations during the pendency
1559 of the protest or any subsequent appeal.
1560 (iii) The payment shall be accompanied by a statement in writing:
1561 (A) that the payment is made under protest; and
1562 (B) giving a brief description of the grounds for the protest.
1563 (b) (i) The association shall notify the member insurer, in writing, of the association's
1564 determination with respect to the protest within 60 days after the day on which the payment of
1565 an assessment is made under protest by a member insurer, unless the association notifies the
1566 member insurer that additional time is required to resolve the issues raised by the protest.
1567 (ii) The association shall notify the protesting member insurer in writing of the final
1568 decision within 30 days after the day on which a final decision is made by the association.
1569 (iii) The protesting member insurer may appeal the final action of the association to the

1570 commissioner within 60 days after the day on which the protesting member insurer receives a
1571 notice of the final decision from the association.
1572 (c) The association may refer protests to the commissioner for a final decision, with or
1573 without a recommendation from the association.
1574 (d) (i) If a protest or appeal on an assessment concludes that an amount was paid in
1575 error or excess by a member insurer, the association shall return the amount paid in error or
1576 excess to the member insurer.
1577 (ii) The association shall pay interest on a refund due to a protesting member insurer at
1578 the rate actually earned by the association.
1579 [(9)] (10) (a) The association may request information from a member insurer to aid in
1580 the exercise of the association's power under this part.
1581 (b) A member insurer shall comply promptly with a request of the association under
1582 this Subsection [(9)] (10).
1583 Section 12. Section **31A-28-111** is amended to read:
1584 **31A-28-111. Duties and powers under this part.**
1585 [In] The duties and powers described in this section are in addition to the duties and
1586 powers enumerated elsewhere in this part[, the persons described in this section have the duties
1587 and powers described in Subsections (1) through (6)].
1588 (1) The commissioner shall:
1589 (a) upon request of the board of directors, provide the association with a statement of
1590 the premiums for each member insurer:
1591 (i) in this state; and
1592 (ii) any other appropriate state; and
1593 (b) if an impairment is declared and the amount of the impairment is determined, serve
1594 a demand upon the impaired insurer to make good the impairment within a reasonable time.
1595 (2) Notice to the impaired insurer under Subsection (1)(b) constitutes notice to the
1596 shareholders of the impaired insurer if the impaired insurer has shareholders.
1597 (3) The failure of the impaired insurer to promptly comply with the commissioner's

1598 demand under Subsection (1)(b) does not excuse the association from the performance of its
1599 powers and duties under this part.
1600 (4) (a) After notice and hearing, the commissioner may suspend or revoke the
1601 certificate of authority to transact [~~insurance~~] business in this state of a member insurer not
1602 domiciled in this state that fails to:
1603 (i) pay an assessment when due; or
1604 (ii) comply with the plan of operation.
1605 (b) (i) As an alternative to suspending or revoking a certificate of authority under
1606 Subsection (4)(a), the commissioner may levy a forfeiture on any member insurer that fails to
1607 pay an assessment when due.
1608 (ii) A forfeiture described in Subsection (4)(b)(i):
1609 (A) may not exceed 5% of the unpaid assessment per month; and
1610 (B) may not be less than $100 per month.
1611 (5) (a) A final action of the board of directors or the association may be appealed to the
1612 commissioner by any member insurer if appeal is taken within 60 days of the date the member
1613 insurer received notice of the final action being appealed.
1614 (b) If a member insurer is appealing an assessment, the amount assessed shall be:
1615 (i) paid to the association; and
1616 (ii) made available to meet association obligations during the pendency of an appeal.
1617 (c) If the appeal on the assessment described in Subsection (5)(b) is upheld, the amount
1618 paid in error or excess shall be returned to the member insurer.
1619 (d) Any final action or order of the commissioner is subject to judicial review in a court
1620 of competent jurisdiction in accordance with the laws of this state that apply to the actions or
1621 orders of the commissioner.
1622 (6) The receiver of an impaired insurer shall notify the interested persons of the effect
1623 of this part.
1624 Section 13. Section **31A-28-112** is amended to read:
1625 **31A-28-112. Reports.**

1626 (1) The commissioner shall:
1627 (a) report to the board of directors when:
1628 (i) the commissioner takes an action set forth in Section 31A-27a-201;
1629 (ii) an event described in Section 31A-17-603, 31A-17-604, or 31A-17-605 occurs; or
1630 (iii) the commissioner receives a report from any other commissioner indicating that an
1631 action described in Subsection (1)(a)(i) has been taken in another state;
1632 (b) include in the report to the board of directors required by Subsection (1)(a):
1633 (i) the significant details of the action taken;
1634 (ii) the significant details of an event described in Subsection (1)(a)(ii); or
1635 (iii) the report received from another commissioner;
1636 (c) promptly report to the board of directors when the commissioner has reasonable
1637 cause to believe from an examination of any member insurer, whether completed or in process,
1638 that the member insurer may be an impaired or insolvent insurer; and
1639 (d) furnish to the board of directors the National Association of Insurance
1640 Commissioners Insurance Regulatory Information System ratios and listings of companies not
1641 included in the ratios developed by the National Association of Insurance Commissioners.
1642 (2) (a) The board of directors may use the information contained in the ratios and
1643 listings described in Subsection (1)(d) in carrying out the board of directors' duties and
1644 responsibilities under this part.
1645 (b) The board of directors shall keep the report and the information contained in the
1646 ratios and listings confidential until the commissioner or other lawful authority publishes the
1647 information.
1648 (3) The commissioner may seek the advice and recommendations of the board of
1649 directors concerning any matter affecting the commissioner's duties and responsibilities
1650 regarding the financial condition of member insurers and companies seeking admission to
1651 transact insurance business in this state.
1652 (4) (a) The board of directors may make reports and recommendations to the
1653 commissioner upon any matter germane to:

1654 (i) the solvency, liquidation, rehabilitation, or conservation of any member insurer; or
1655 (ii) the solvency of any [company] insurer seeking to do [an insurance] business in this
1656 state.
1657 (b) The reports and recommendations of the board of directors described in Subsection
1658 (4)(a) are not public documents.
1659 (5) The board of directors may, upon majority vote, notify the commissioner of any
1660 information indicating that a member insurer may be an impaired or insolvent insurer.
1661 (6) The board of directors may make recommendations to the commissioner for the
1662 detection and prevention of member insurer insolvencies.
1663 (7) (a) At the conclusion of any member insurer insolvency in which the association
1664 was obligated to pay covered claims, the board of directors shall prepare a report to the
1665 commissioner containing the information the board of directors has in its possession bearing on
1666 the history and causes of the insolvency.
1667 (b) In preparing a report on the history and causes of insolvency of a particular member
1668 insurer, the board of directors may cooperate with:
1669 (i) the board of directors of a guaranty association in another state; or
1670 (ii) an organization described in Subsection 31A-28-108(16).
1671 (c) The board of directors may adopt by reference any report prepared by:
1672 (i) a guaranty association in another state; or
1673 (ii) an organization described in Subsection 31A-28-108(16).
1674 Section 14. Section **31A-28-113** is amended to read:
1675 **31A-28-113. Credit for assessments paid.**
1676 (1) (a) A member insurer may offset against its premium tax, income tax, or franchise
1677 tax liability to this state an assessment described in Subsection 31A-28-109(2)(b) to the extent
1678 of 20% of the amount of the assessment for each of the five calendar years following the year
1679 in which the assessment was paid.
1680 (b) To the extent that the offsets described in Subsection (1)(a) exceed premium tax
1681 liability, the offsets may be carried forward and used to offset premium tax liability in future

1682 years.

1683 (c) If a member insurer ceases doing business, all uncredited assessments may be
1684 credited against its premium tax liability for the year it ceases doing business.

1685 (2) (a) A member insurer that is exempt from taxes described in Subsection (1) may
1686 recoup the member insurer's assessment by a surcharge on premiums in a sum reasonably
1687 calculated to recoup the assessments over a reasonable period of time, as approved by the
1688 commissioner.

1689 (b) Amounts recouped shall not be considered premiums for any other purpose,
1690 including the computation of gross premium tax, income tax, franchise tax, producer
1691 commission, or, to the extent allowed under federal law, medical loss ratio.

1692 (c) If a member insurer collects excess surcharges, the member insurer shall remit the
1693 excess amount to the association, and the excess amount shall be applied to reduce future
1694 assessments in the appropriate account.

1695 [~~(2)~~] (3) (a) Money shall be paid by the member insurers to the state in a manner
1696 required by the State Tax Commission if the money:

1697 (i) is acquired by refund in accordance with Subsection 31A-28-109(6) from the
1698 association by member insurers; and

1699 (ii) has been offset against premium taxes as provided in Subsection (1).

1700 (b) The association shall notify the commissioner that the refunds described in
1701 Subsection [~~(2)~~] (3)(a) have been made.

1702 Section 15. Section **31A-28-114** is amended to read:

1703 **31A-28-114. Miscellaneous provisions.**

1704 (1) Nothing in this part shall be construed to reduce the liability for unpaid assessments
1705 of the insureds of an impaired or insolvent insurer operating under a plan with assessment
1706 liability.

1707 (2) (a) The board of directors shall keep a record of a meeting of the board of directors
1708 to discuss the activities of the association in carrying out its powers and duties under Section
1709 31A-28-108.

1710 (b) A record of the association with respect to an impaired or insolvent insurer may not
1711 be disclosed before the earlier of:
1712 (i) the termination of a liquidation, rehabilitation, or conservation proceeding involving
1713 the impaired or insolvent insurer;
1714 (ii) the termination of the impairment or insolvency of the insurer; or
1715 (iii) upon the order of a court of competent jurisdiction.
1716 (c) Nothing in this Subsection (2) limits the duty of the association to render a report of
1717 its activities under Section 31A-28-115.
1718 (3) (a) For the purpose of carrying out its obligations under this part, the association is
1719 considered to be a creditor of an impaired or insolvent insurer to the extent of assets
1720 attributable to covered policies or contracts reduced by any amounts to which the association is
1721 entitled as subrogee pursuant to Subsection 31A-28-108(14).
1722 (b) Assets of the impaired or insolvent insurer attributable to covered policies or
1723 contracts shall be used to continue the covered policies and pay the contractual obligations of
1724 the impaired or insolvent insurer as required by this part.
1725 (c) As used in this Subsection (3), assets attributable to covered policies or contracts
1726 are that proportion of the assets which the reserves that should have been established for
1727 covered policies or contracts bear to the reserves that should have been established for all
1728 policies of insurance written by the impaired or insolvent insurer.
1729 (4) (a) As a creditor of the impaired or insolvent insurer under Subsection (3) and
1730 consistent with Section 31A-27a-701, the association and any other similar association are
1731 entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the
1732 assets become available to reimburse the association and any other similar association.
1733 (b) If, within 180 days of a final determination of insolvency of [an] a member insurer
1734 by the receivership court, the receiver has not made an application to the court for the approval
1735 of a proposal to disburse assets out of marshaled assets to the guaranty associations having
1736 obligations because of the insolvency, the association is entitled to make application to the
1737 receivership court for approval of the association's proposal for disbursement of these assets.

1738 (5) (a) Before the termination of a liquidation, rehabilitation, or conservation
1739 proceeding, when making an equitable distribution of the ownership rights of the insolvent
1740 insurer, the court may take into consideration the contributions of the respective parties,
1741 including:
1742 (i) the association;
1743 (ii) the shareholders;
1744 (iii) [policyowners] policy owners, contract owners, certificate holders, and enrollees
1745 of the insolvent insurer; and
1746 (iv) any other party with a bona fide interest in making an equitable distribution of the
1747 ownership rights of the insolvent insurer.
1748 (b) In making a determination under Subsection (5)(a), the court shall consider the
1749 welfare of the [policyowners] policy owners, contract owners, certificate holders, and enrollees
1750 of the continuing or successor member insurer.
1751 (c) A distribution to any stockholder of an impaired or insolvent insurer may not be
1752 made until and unless the total amount of valid claims of the association with interest has been
1753 fully recovered by the association for funds expended in carrying out its powers and duties
1754 under Section 31A-28-108 with respect to the member insurer.
1755 Section 16. Section **31A-28-119** is amended to read:
1756 **31A-28-119. Prohibited advertisement of the association -- Notice to owners of**
1757 **policies and contracts.**
1758 (1) (a) Except as provided in Subsection (1)(b), a person, including [an] a member
1759 insurer, [agent] producer, or affiliate of [an] a member insurer may not make, publish,
1760 disseminate, circulate, or place before the public, or cause directly or indirectly to be made,
1761 published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or
1762 other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over a radio
1763 station or television station, or in any other way, any advertisement, announcement, or
1764 statement written or oral, that uses the existence of the association for the purpose of sales,
1765 solicitation, or inducement to purchase any form of insurance or coverage for which the

1766 guaranty association provides coverage under this part.
1767 (b) [~~Notwithstanding Subsection (1)(a), this~~] This section does not apply to:
1768 (i) the association; or
1769 (ii) another entity that does not sell or solicit insurance.
1770 (2) (a) The association shall:
1771 (i) have a summary document describing the general purposes and current limitations
1772 of this part that complies with Subsection (3); and
1773 (ii) submit the summary document described in Subsection (2)(a)(i) to the
1774 commissioner for approval.
1775 (b) [~~An~~] A member insurer may not deliver a policy or contract to a policy [~~or~~] owner,
1776 contract owner, certificate holder, or enrollee unless the summary document is also delivered to
1777 the policy [~~or~~] owner, contract owner, certificate holder, or enrollee before, or at the time of,
1778 delivery of the policy or contract.
1779 (c) The summary document shall be available upon request by a policy owner, contract
1780 owner, certificate holder, or enrollee.
1781 (d) The distribution, delivery, or contents or interpretation of the summary document
1782 does not guarantee that:
1783 (i) the policy or the contract is covered in the event of the impairment or insolvency of
1784 a member insurer; or
1785 (ii) the [~~owner of the policy or~~] policy owner, contract owner, certificate holder, or
1786 enrollee is covered in the event of the impairment or insolvency of a member insurer.
1787 (e) The summary document shall be revised by the association as amendments to this
1788 part may require.
1789 (f) Failure to receive the summary document as required in Subsection (2)(b) does not
1790 give the [~~owner of a policy or~~] policy owner, contract owner, certificate holder, enrollee, or
1791 insured any greater rights than those stated in this part.
1792 (3) (a) The summary document described in Subsection (2) shall contain a clear and
1793 conspicuous disclaimer on its face.

1794 (b) The commissioner shall, by rule, establish the form and content of the disclaimer
1795 described in Subsection (3)(a), except that the disclaimer shall:
1796 (i) state the name and address of:
1797 (A) the association; and
1798 (B) the department;
1799 (ii) prominently warn a policy [~~or~~] owner, contract owner, certificate holder, or
1800 enrollee that:
1801 (A) the association may not cover the policy or contract; or
1802 (B) if coverage is available, it is:
1803 (I) subject to substantial limitations and exclusions; and
1804 (II) conditioned on continued residence in the state;
1805 (iii) state the types of policies or contracts for which the association will provide
1806 coverage;
1807 (iv) state that the member insurer and [~~its agents~~] the member insurer's producers are
1808 prohibited by law from using the existence of the association for the purpose of sales,
1809 solicitation, or inducement to purchase any form of insurance;
1810 (v) state that the policy [~~or~~] owner, contract owner, certificate holder, or enrollee
1811 should not rely on coverage under the association when selecting an insurer;
1812 (vi) explain the rights available and procedures for filing a complaint to allege a
1813 violation of this part; and
1814 (vii) provide other information as directed by the commissioner including sources for
1815 information about the financial condition of insurers provided that the information:
1816 (A) is not proprietary; and
1817 (B) is subject to disclosure under public records laws.
1818 (4) (a) An insurer, or [~~agent~~] the insurer's producer, may not deliver a policy or contract
1819 described in Subsection 31A-28-103[~~(2)(a)~~](6) and wholly excluded under Subsection
1820 31A-28-103[~~(2)(b)(i)~~](7)(a) from coverage under this part unless the insurer or [~~agent~~] the
1821 insurer's producer, prior to or at the time of delivery, gives the policy [~~or~~] owner, contract

1822 owner, certificate holder, or enrollee a separate written notice that clearly and conspicuously
1823 discloses that the policy or contract is not covered by the association.
1824 (b) The commissioner shall by rule specify the form and content of the notice required
1825 by Subsection (4)(a).
1826 (5) A member insurer shall retain evidence of compliance with Subsection (2) for the
1827 later of:
1828 (a) three years; or
1829 (b) until the conclusion of the next market conduct examination by the department of
1830 insurance where the member insurer is domiciled.
1831 Section 17. Section **31A-28-120** is amended to read:
1832 **31A-28-120. Prospective application.**
1833 Notwithstanding any prior or subsequent law, the provisions of this part that are in
1834 effect on the date on which the association first becomes obligated for the policies or contracts
1835 of an insolvent or impaired [~~member~~] insurer govern the association's rights and obligations to
1836 the [~~policyowners~~] policy owners, contract owners, certificate holders, and enrollees of the
1837 insolvent or impaired [~~member~~] insurer.
1838 Section 18. Section **59-7-623** is enacted to read:
1839 **59-7-623. Nonrefundable guaranty association assessment tax credit.**
1840 (1) As used in this section:
1841 (a) "Guaranty association assessment" means the amount of any assessments paid by a
1842 qualified insurer under the guaranty association established under Title 31A, Chapter 28, Part
1843 1, Utah Life and Health Insurance Guaranty Association Act, in the manner provided by
1844 Section 31A-28-113.
1845 (b) "Qualified insurer" means an insurer, as defined in Section 31A-1-301, that is not
1846 subject to the premium tax on health care insurance under Section 59-9-101.
1847 (2) For a taxable year beginning on or after January 1, 2019, a qualified insurer may
1848 claim a nonrefundable tax credit equal to 20% of the assessment for each of the five years
1849 following the year the qualified insurer pays a guaranty association assessment, in accordance

1850 with Section 31A-28-113.

1851 (3) (a) A qualified insurer may carry forward the portion of the tax credit that exceeds

1852 the qualified insurer's tax liability for the taxable year in accordance with Section 31A-28-113.

1853 (b) A qualified insurer may not carry back the portion of the tax credit that exceeds the

1854 qualified insurer's tax liability for the taxable year.

1855 Section 19. **Effective date.**

1856 This bill takes effect on January 1, 2019.