

**Senator Curtis S. Bramble** proposes the following substitute bill:

**INSURANCE MODIFICATIONS**

2018 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: James A. Dunnigan**

Senate Sponsor: Curtis S. Bramble

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**LONG TITLE**

**General Description:**

This bill modifies provisions related to insurance.

**Highlighted Provisions:**

This bill:

- ▶ defines terms and modifies defined terms;
- ▶ adds provisions that a warrantor is required to disclose in a vehicle protection product warranty;
- ▶ repeals the requirement that the fixed amount of reimbursement under a vehicle protection product warranty is uniform for all warranty holders of the same vehicle protection product warranty;
- ▶ addresses the requirements for filing a binder for a health benefit plan or dental policy with the commissioner;
- ▶ modifies the date on which the commissioner presents an annual evaluation of the state's health insurance market;
- ▶ classifies certain records related to an examination as protected records;
- ▶ modifies the membership of the Title and Escrow Commission;
- ▶ modifies provisions related to the Captive Insurance Restricted Account;
- ▶ enacts and consolidates provisions related to an offer of qualified health insurance





- 26 coverage that certain contractors and subcontractors are required to obtain and maintain;
- 27       ▶ amends the threshold at which certain contractors and subcontractors become
- 28 subject to certain health care-related requirements;
- 29       ▶ modifies the process by which the commissioner determines an applicant's ability to
- 30 provide proposed health care services under Title 31A, Chapter 8, Health
- 31 Maintenance Organizations and Limited Health Plans;
- 32       ▶ modifies the requirements for a nonadmitted insurer to be listed on the
- 33 commissioner's "reliable" list;
- 34       ▶ provides the circumstances under which the commissioner must hold a hearing on a
- 35 merger or other acquisition of an insurer;
- 36       ▶ amends the deadline for holding a hearing on a merger or other acquisition of an
- 37 insurer;
- 38       ▶ allows an insurer to terminate coverage of a spouse of an insured under an accident
- 39 and health insurance policy in the event of legal separation;
- 40       ▶ prohibits an insured from charging any additional amount for electing to extend
- 41 group coverage;
- 42       ▶ addresses the timing of open enrollment for individuals who extend or are eligible
- 43 to extend group coverage;
- 44       ▶ addresses the commissioner's authority to take action against a person who has had
- 45 an insurance license or other professional or occupational license denied,
- 46 suspended, revoked, or surrendered to resolve an administrative action;
- 47       ▶ addresses the circumstances under which an individual title insurance producer or
- 48 agency title insurance producer may do escrow involving real property transactions;
- 49       ▶ provides that the commissioner may take action against a licensee if the
- 50 commissioner finds that the licensee is convicted of a misdemeanor involving fraud,
- 51 misrepresentation, theft, or dishonesty;
- 52       ▶ modifies the training and continuing education requirements for certain licensees;
- 53       ▶ amends provisions related to the effect of an insurer's insolvency;
- 54       ▶ clarifies the process by which the state designates the essential health benefits for
- 55 the state;
- 56       ▶ repeals certain sections of the Insurance Code;

- 57           ▶ modifies the workers' compensation advisory council's reporting requirements;
- 58           ▶ authorizes the Labor Commission to use funds from the Industrial Accident
- 59 Restricted Account for specific purposes; and
- 60           ▶ makes technical and conforming changes.

61 **Money Appropriated in this Bill:**

62           None

63 **Other Special Clauses:**

64           None

65 **Utah Code Sections Affected:**

66 AMENDS:

- 67           **17B-2a-818.5**, as last amended by Laws of Utah 2016, Chapters 20 and 355
- 68           **19-1-206**, as last amended by Laws of Utah 2016, Chapters 20 and 355
- 69           **26-18-402**, as last amended by Laws of Utah 2013, Chapter 278
- 70           **26-40-115**, as last amended by Laws of Utah 2016, Chapter 20
- 71           **31A-1-301**, as last amended by Laws of Utah 2017, Chapter 292
- 72           **31A-2-201.1**, as last amended by Laws of Utah 2008, Chapter 382
- 73           **31A-2-201.2**, as last amended by Laws of Utah 2017, Chapter 292
- 74           **31A-2-204**, as last amended by Laws of Utah 2008, Chapter 382
- 75           **31A-2-403**, as last amended by Laws of Utah 2015, Chapter 330
- 76           **31A-3-303**, as last amended by Laws of Utah 2011, Chapters 62 and 275
- 77           **31A-3-304**, as last amended by Laws of Utah 2017, Chapter 168
- 78           **31A-6a-101**, as last amended by Laws of Utah 2017, Chapter 27
- 79           **31A-6a-104**, as last amended by Laws of Utah 2016, Chapter 138
- 80           **31A-6a-105**, as last amended by Laws of Utah 2015, Chapter 244
- 81           **31A-8-104**, as last amended by Laws of Utah 1997, Chapter 185
- 82           **31A-8a-102**, as last amended by Laws of Utah 2013, Chapters 104 and 135
- 83           **31A-15-103**, as last amended by Laws of Utah 2017, Chapter 363
- 84           **31A-16-103**, as last amended by Laws of Utah 2015, Chapter 244
- 85           **31A-22-612**, as last amended by Laws of Utah 2015, Chapter 244
- 86           **31A-22-618.6**, as last amended by Laws of Utah 2017, Chapter 168 and renumbered
- 87 and amended by Laws of Utah 2017, Chapter 292

- 88            **31A-22-629**, as last amended by Laws of Utah 2012, Chapter 253
- 89            **31A-22-701**, as last amended by Laws of Utah 2017, Chapter 168
- 90            **31A-22-722**, as last amended by Laws of Utah 2013, Chapter 319
- 91            **31A-23a-107**, as last amended by Laws of Utah 2012, Chapter 253
- 92            **31A-23a-109**, as last amended by Laws of Utah 2012, Chapter 253
- 93            **31A-23a-111**, as last amended by Laws of Utah 2017, Chapter 168
- 94            **31A-23a-208**, as enacted by Laws of Utah 2013, Chapter 341
- 95            **31A-23a-406**, as last amended by Laws of Utah 2013, Chapter 319
- 96            **31A-23b-102**, as last amended by Laws of Utah 2017, Chapter 168
- 97            **31A-23b-202.5**, as last amended by Laws of Utah 2017, Chapter 168
- 98            **31A-23b-204**, as enacted by Laws of Utah 2013, Chapter 341
- 99            **31A-23b-205**, as last amended by Laws of Utah 2014, Chapters 290, 300, 425 and last
- 100 amended by Coordination Clause, Laws of Utah 2014, Chapters 300, and 425
- 101            **31A-23b-206**, as last amended by Laws of Utah 2015, Chapter 244
- 102            **31A-25-204**, as enacted by Laws of Utah 1985, Chapter 242
- 103            **31A-25-206**, as last amended by Laws of Utah 2001, Chapter 116
- 104            **31A-26-102**, as last amended by Laws of Utah 2014, Chapters 290 and 300
- 105            **31A-26-205**, as last amended by Laws of Utah 1986, Chapter 204
- 106            **31A-26-208**, as last amended by Laws of Utah 2011, Chapter 284
- 107            **31A-27a-111**, as enacted by Laws of Utah 2007, Chapter 309
- 108            **31A-27a-608**, as enacted by Laws of Utah 2007, Chapter 309
- 109            **31A-30-210**, as enacted by Laws of Utah 2010, Chapter 229
- 110            **31A-43-303**, as last amended by Laws of Utah 2014, Chapters 290 and 300
- 111            **34A-2-107**, as last amended by Laws of Utah 2017, Chapters 18 and 363
- 112            **34A-2-705**, as last amended by Laws of Utah 2011, Chapter 328
- 113            **63A-5-205**, as last amended by Laws of Utah 2016, Chapters 20 and 355
- 114            **63C-9-403**, as last amended by Laws of Utah 2016, Chapters 20 and 355
- 115            **63G-2-305**, as last amended by Laws of Utah 2017, Chapters 374, 382, and 415
- 116            **72-6-107.5**, as last amended by Laws of Utah 2016, Chapters 20 and 355
- 117            **79-2-404**, as last amended by Laws of Utah 2016, Chapters 20 and 355

118 ENACTS:

119 [31A-45-403](#), Utah Code Annotated 1953

120 [63A-5-205.5](#), Utah Code Annotated 1953

121 REPEALS AND REENACTS:

122 [31A-6a-111](#), as enacted by Laws of Utah 2015, Chapter 244

123 REPEALS:

124 [31A-22-722.5](#), as last amended by Laws of Utah 2011, Chapters 297 and 340

125 [31A-30-209](#), as last amended by Laws of Utah 2016, Chapter 138

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

128 Section 1. Section [17B-2a-818.5](#) is amended to read:

129 **[17B-2a-818.5. Contracting powers of public transit districts -- Health insurance](#)**  
130 **coverage.**

131 (1) [~~For purposes of~~] As used in this section:

132 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
133 related to a single project.

134 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

135 [~~(a)~~] (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee,"  
136 "worker," or "operative" [~~as defined in Section [34A-2-104](#)]~~ who:

137 (i) works at least 30 hours per calendar week; and

138 (ii) meets employer eligibility waiting requirements for health care insurance, which  
139 may not exceed the first day of the calendar month following 60 days [~~from the date of hire~~]  
140 after the day on which the individual is hired.

141 [~~(b)~~] (d) "Health benefit plan" means the same as that term is defined in Section  
142 [31A-1-301](#).

143 [~~(e)~~] (e) "Qualified health insurance coverage" means the same as that term is defined  
144 in Section [26-40-115](#).

145 [~~(d)~~] (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).

146 [~~(2)(a)~~] Except as provided in Subsection (3), this section applies to a design or  
147 construction contract entered into by the public transit district on or after July 1, 2009, and to a  
148 prime contractor or to a subcontractor in accordance with Subsection (2)(b).]

149 [~~(b)(i)~~] A prime contractor is subject to this section if the prime contract is in the

150 amount of \$2,000,000 or greater at the original execution of the contract.]

151 ~~[(ii) A subcontractor is subject to this section if a subcontract is in the amount of~~  
152 ~~\$1,000,000 or greater at the original execution of the contract.]~~

153 ~~[(3) This section does not apply if:]~~

154 (2) Except as provided in Subsection (3), the requirements of this section apply to:

155 (a) a contractor of a design or construction contract entered into by the public transit  
156 district on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or  
157 greater than \$2,000,000; and

158 (b) a subcontractor of a contractor of a design or construction contract entered into by  
159 the public transit district on or after July 1, 2009, if the subcontract is in an aggregate amount  
160 equal to or greater than \$1,000,000.

161 (3) The requirements of this section do not apply to a contractor or subcontractor  
162 described in Subsection (2) if:

163 (a) the application of this section jeopardizes the receipt of federal funds;

164 (b) the contract is a sole source contract; or

165 (c) the contract is an emergency procurement.

166 ~~[(4) (a) This section does not apply to a change order as defined in Section~~  
167 ~~63G-6a-103, or a modification to a contract, when the contract does not meet the initial~~  
168 ~~threshold required by Subsection (2).]~~

169 ~~[(b) (4) A person [who] that intentionally uses change orders [or], contract~~  
170 ~~modifications, or multiple contracts to circumvent the requirements of [Subsection (2)] this~~  
171 ~~section is guilty of an infraction.~~

172 (5) (a) A contractor subject to [Subsection (2)] the requirements of this section shall  
173 demonstrate to the public transit district that the contractor has and will maintain an offer of  
174 qualified health insurance coverage for the contractor's employees and the employee's  
175 dependents during the duration of the contract[-] by submitting to the public transit district a  
176 written statement that:

177 ~~[(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor~~  
178 ~~shall:]~~

179 (i) certifies that the contractor offers qualified health insurance coverage in accordance  
180 with Section 26-40-115;

181 (ii) is from:  
182 (A) an actuary selected by the contractor or the contractor's insurer; or  
183 (B) an underwriter who is responsible for developing the employer group's premium  
184 rates; and  
185 (iii) was created within one year before the day on which the statement is submitted.  
186 (b) A contractor that is subject to the requirements of this section shall:  
187 (i) place a requirement in [the subcontract that the subcontractor] each of the  
188 contractor's subcontracts that a subcontractor that is subject to the requirements of this section  
189 shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's  
190 employees and the employees' [dependants] dependents during the duration of the subcontract;  
191 and  
192 [~~(ii) certify to the public transit district that the subcontractor has and will maintain an~~  
193 ~~offer of qualified health insurance coverage for the subcontractor's employees and the~~  
194 ~~employees' dependents during the duration of the prime contract.]~~  
195 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
196 written statement that:  
197 (A) certifies that the subcontractor offers qualified health insurance coverage in  
198 accordance with Section [26-40-115](#);  
199 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an  
200 underwriter who is responsible for developing the employer group's premium rates; and  
201 (C) was created within one year before the day on which the contractor obtains the  
202 statement.  
203 (c) (i) (A) A contractor [~~who fails to meet the requirements of] that fails to maintain an~~  
204 offer of qualified health insurance coverage as described in Subsection (5)(a) during the  
205 duration of the contract is subject to penalties in accordance with an ordinance adopted by the  
206 public transit district under Subsection (6).  
207 (B) A contractor is not subject to penalties for the failure of a subcontractor to [~~meet~~  
208 ~~the requirements of] obtain and maintain an offer of qualified health insurance coverage~~  
209 described in Subsection (5)(b)(i).  
210 (ii) (A) A subcontractor [~~who fails to meet the requirements of] that fails to obtain and~~  
211 maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i)

212 during the duration of the ~~[contract]~~ subcontract is subject to penalties in accordance with an  
 213 ordinance adopted by the public transit district under Subsection (6).

214 (B) A subcontractor is not subject to penalties for the failure of a contractor to ~~[meet~~  
 215 ~~the requirements of]~~ maintain an offer of qualified health insurance coverage described in  
 216 Subsection (5)(a).

217 (6) The public transit district shall adopt ordinances:

218 (a) in coordination with:

219 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

220 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

221 (iii) the State Building Board in accordance with Section ~~[63A-5-205]~~ 63A-5-205.5;

222 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and

223 (v) the Department of Transportation in accordance with Section 72-6-107.5; and

224 (b) that establish:

225 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
 226 demonstrate ~~[to the public transit district]~~ compliance with this section ~~[that shall include]~~,  
 227 including:

228 ~~[(A) that a contractor shall demonstrate compliance with Subsection (5)(a) or (b) at the~~  
 229 ~~time of the execution of each initial contract described in Subsection (2)(b);]~~

230 ~~[(B) that the contractor's]~~

231 (A) that a contractor or subcontractor's compliance with this section is subject to an  
 232 audit by the public transit district or the Office of the Legislative Auditor General; ~~[and]~~

233 ~~[(C) that the actuarially equivalent determination required for the qualified health~~  
 234 ~~insurance coverage in Subsection (1) is met by the contractor if the contractor provides the~~  
 235 ~~department or division with a written statement of actuarial equivalency, which is no more than~~  
 236 ~~one year old, regarding the contractor's offer of qualified health coverage from an actuary~~  
 237 ~~selected by the contractor or the contractor's insurer, or an underwriter who is responsible for~~  
 238 ~~developing the employer group's premium rates;]~~

239 (B) that a contractor that is subject to the requirements of this section shall obtain a  
 240 written statement described in Subsection (5)(a); and

241 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
 242 written statement described in Subsection (5)(b)(ii);

243 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
244 violates the provisions of this section, which may include:

245 (A) a three-month suspension of the contractor or subcontractor from entering into  
246 future contracts with the public transit district upon the first violation;

247 (B) a six-month suspension of the contractor or subcontractor from entering into future  
248 contracts with the public transit district upon the second violation;

249 (C) an action for debarment of the contractor or subcontractor in accordance with  
250 Section 63G-6a-904 upon the third or subsequent violation; and

251 (D) monetary penalties which may not exceed 50% of the amount necessary to  
252 purchase qualified health insurance coverage for employees and dependents of employees of  
253 the contractor or subcontractor who were not offered qualified health insurance coverage  
254 during the duration of the contract; and

255 (iii) a website on which the district shall post the commercially equivalent benchmark,  
256 for the qualified health insurance coverage identified in Subsection (1)~~(f)~~(e), that is provided  
257 by the Department of Health, in accordance with Subsection 26-40-115(2).

258 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(b)(ii), a contractor  
259 or subcontractor who intentionally violates the provisions of this section ~~shall be~~ is liable to  
260 the employee for health care costs that would have been covered by qualified health insurance  
261 coverage.

262 (ii) An employer has an affirmative defense to a cause of action under Subsection  
263 (7)(a)(i) if:

264 (A) the employer relied in good faith on a written statement ~~[of actuarial equivalency~~  
265 ~~provided by an:]~~ described in Subsection (5)(a) or (5)(b)(ii); or

266 ~~[(f) actuary; or]~~

267 ~~[(H) underwriter who is responsible for developing the employer group's premium~~  
268 ~~rates; or]~~

269 (B) a department or division determines that compliance with this section is not  
270 required under the provisions of Subsection (3) ~~[or (4)]~~.

271 (b) An employee has a private right of action only against the employee's employer to  
272 enforce the provisions of this Subsection (7).

273 (8) Any penalties imposed and collected under this section shall be deposited into the

274 Medicaid Restricted Account created in Section [26-18-402](#).

275 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
276 coverage as required by this section:

277 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
278 or contractor under:

279 (i) Section [63G-6a-1602](#); or

280 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

281 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
282 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
283 or construction.

284 Section 2. Section **19-1-206** is amended to read:

285 **19-1-206. Contracting powers of department -- Health insurance coverage.**

286 (1) ~~[For purposes of]~~ As used in this section:

287 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
288 related to a single project.

289 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

290 ~~[(a)]~~ (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee,"

291 "worker," or "operative" ~~[as defined in Section [34A-2-104](#)]~~ who:

292 (i) works at least 30 hours per calendar week; and

293 (ii) meets employer eligibility waiting requirements for health care insurance, which  
294 may not exceed the first day of the calendar month following 60 days ~~[from the date of hire]~~  
295 after the day on which the individual is hired.

296 ~~[(b)]~~ (d) "Health benefit plan" means the same as that term is defined in Section  
297 [31A-1-301](#).

298 ~~[(e)]~~ (e) "Qualified health insurance coverage" means the same as that term is defined  
299 in Section [26-40-115](#).

300 ~~[(d)]~~ (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).

301 ~~[(2)(a)]~~ Except as provided in Subsection (3), this section applies to a design or  
302 construction contract entered into by or delegated to the department or a division or board of  
303 the department on or after July 1, 2009, and to a prime contractor or subcontractor in  
304 accordance with Subsection (2)(b).]

305 ~~[(b) (i) A prime contractor is subject to this section if the prime contract is in the~~  
306 ~~amount of \$2,000,000 or greater at the original execution of the contract.]~~

307 ~~[(ii) A subcontractor is subject to this section if a subcontract is in the amount of~~  
308 ~~\$1,000,000 or greater at the original execution of the contract.]~~

309 (2) Except as provided in Subsection (3), the requirements of this section apply to:

310 (a) a contractor of a design or construction contract entered into by, or delegated to, the  
311 department, or a division or board of the department, on or after July 1, 2009, if the prime  
312 contract is in an aggregate amount equal to or greater than \$2,000,000; and

313 (b) a subcontractor of a contractor of a design or construction contract entered into by,  
314 or delegated to, the department, or a division or board of the department, on or after July 1,  
315 2009, if the subcontract is in an aggregate amount equal to or greater than \$1,000,000.

316 (3) This section does not apply to contracts entered into by the department or a division  
317 or board of the department if:

318 (a) the application of this section jeopardizes the receipt of federal funds;

319 (b) the contract or agreement is between:

320 (i) the department or a division or board of the department; and

321 (ii) (A) another agency of the state;

322 (B) the federal government;

323 (C) another state;

324 (D) an interstate agency;

325 (E) a political subdivision of this state; or

326 (F) a political subdivision of another state;

327 (c) the executive director determines that applying the requirements of this section to a  
328 particular contract interferes with the effective response to an immediate health and safety  
329 threat from the environment; or

330 (d) the contract is:

331 (i) a sole source contract; or

332 (ii) an emergency procurement.

333 ~~[(4) (a) This section does not apply to a change order as defined in Section~~  
334 ~~63G-6a-103, or a modification to a contract, when the contract does not meet the initial~~  
335 ~~threshold required by Subsection (2).]~~

336 ~~[(b)]~~ (4) A person ~~[who]~~ that intentionally uses change orders ~~[or]~~, contract  
 337 modifications, or multiple contracts to circumvent the requirements of ~~[Subsection (2)]~~ this  
 338 section is guilty of an infraction.

339 (5) (a) A contractor subject to ~~[Subsection (2)]~~ the requirements of this section shall  
 340 demonstrate to the executive director that the contractor has and will maintain an offer of  
 341 qualified health insurance coverage for the contractor's employees and the employees'  
 342 dependents during the duration of the contract~~[-]~~ by submitting to the executive director a  
 343 written statement that:

344 ~~[(b) If a subcontractor of the contractor is subject to Subsection (2), the contractor~~  
 345 ~~shall:]~~

346 (i) certifies that the contractor offers qualified health insurance coverage in accordance  
 347 with Section [26-40-115](#);

348 (ii) is from:

349 (A) an actuary selected by the contractor or the contractor's insurer; or

350 (B) an underwriter who is responsible for developing the employer group's premium  
 351 rates; and

352 (iii) was created within one year before the day on which the statement is submitted.

353 (b) A contractor that is subject to the requirements of this section shall:

354 (i) place a requirement in ~~[the subcontract that the subcontractor]~~ each of the  
 355 contractor's subcontracts that a subcontractor that is subject to the requirements of this section  
 356 shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's  
 357 employees and the employees' ~~[dependants]~~ dependents during the duration of the subcontract;  
 358 and

359 ~~[(ii) certify to the executive director that the subcontractor has and will maintain an~~  
 360 ~~offer of qualified health insurance coverage for the subcontractor's employees and the~~  
 361 ~~employees' dependents during the duration of the prime contract.]~~

362 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
 363 written statement that:

364 (A) certifies that the subcontractor offers qualified health insurance coverage in  
 365 accordance with Section [26-40-115](#);

366 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an

367 underwriter who is responsible for developing the employer group's premium rates; and

368 (C) was created within one year before the day on which the contractor obtains the  
369 statement.

370 (c) (i) (A) A contractor [~~who fails to comply with~~] that fails to maintain an offer of  
371 qualified health insurance coverage described in Subsection (5)(a) during the duration of the  
372 contract is subject to penalties in accordance with administrative rules adopted by the  
373 department under Subsection (6).

374 (B) A contractor is not subject to penalties for the failure of a subcontractor to [~~meet~~  
375 ~~the requirements of~~] obtain and maintain an offer of qualified health insurance coverage  
376 described in Subsection (5)(b)(i).

377 (ii) (A) A subcontractor [~~who fails to meet the requirements of~~] that fails to obtain and  
378 maintain an offer of qualified health insurance coverage described in Subsection (5)(b) during  
379 the duration of the [~~contract~~] subcontract is subject to penalties in accordance with  
380 administrative rules adopted by the department under Subsection (6).

381 (B) A subcontractor is not subject to penalties for the failure of a contractor to [~~meet~~  
382 ~~the requirements of~~] maintain an offer of qualified health insurance coverage described in  
383 Subsection (5)(a).

384 (6) The department shall adopt administrative rules:

385 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

386 (b) in coordination with:

387 (i) a public transit district in accordance with Section [17B-2a-818.5](#);

388 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

389 (iii) the State Building Board in accordance with Section [~~63A-5-205~~] [63A-5-205.5](#);

390 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);

391 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and

392 (vi) the Legislature's Administrative Rules Review Committee; and

393 (c) that establish:

394 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
395 demonstrate [~~to the public transit district~~] compliance with this section [~~that shall include~~],  
396 including:

397 [~~(A) that a contractor shall demonstrate compliance with Subsection (5)(a) or (b) at the~~

398 ~~time of the execution of each initial contract described in Subsection (2)(b);]~~

399 ~~[(B) that the contractor's]~~

400 (A) that a contractor or subcontractor's compliance with this section is subject to an  
401 audit by the department or the Office of the Legislative Auditor General; [and]

402 ~~[(C) that the actuarially equivalent determination required for the qualified health~~  
403 ~~insurance coverage in Subsection (1) is met by the contractor if the contractor provides the~~  
404 ~~department or division with a written statement of actuarial equivalency, which is no more than~~  
405 ~~one year old, regarding the contractor's offer of qualified health coverage from an actuary~~  
406 ~~selected by the contractor or the contractor's insurer, or an underwriter who is responsible for~~  
407 ~~developing the employer group's premium rates;]~~

408 (B) that a contractor that is subject to the requirements of this section shall obtain a  
409 written statement described in Subsection (5)(a); and

410 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
411 written statement described in Subsection (5)(b)(ii);

412 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
413 violates the provisions of this section, which may include:

414 (A) a three-month suspension of the contractor or subcontractor from entering into  
415 future contracts with the state upon the first violation;

416 (B) a six-month suspension of the contractor or subcontractor from entering into future  
417 contracts with the state upon the second violation;

418 (C) an action for debarment of the contractor or subcontractor in accordance with  
419 Section 63G-6a-904 upon the third or subsequent violation; and

420 (D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50%  
421 of the amount necessary to purchase qualified health insurance coverage for an employee and  
422 the dependents of an employee of the contractor or subcontractor who was not offered qualified  
423 health insurance coverage during the duration of the contract; and

424 (iii) a website on which the department shall post the commercially equivalent  
425 benchmark, for the qualified health insurance coverage identified in Subsection (1)~~(c)~~(e), that  
426 is provided by the Department of Health, in accordance with Subsection 26-40-115(2).

427 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
428 or subcontractor who intentionally violates the provisions of this section ~~shall be~~ is liable to

429 the employee for health care costs that would have been covered by qualified health insurance  
430 coverage.

431 (ii) An employer has an affirmative defense to a cause of action under Subsection  
432 (7)(a)(i) if:

433 (A) the employer relied in good faith on a written statement [~~of actuarial equivalency~~  
434 ~~provided by:~~ described in Subsection (5)(a) or (5)(b)(ii); or

435 [~~(I) an actuary, or~~

436 [~~(II) an underwriter who is responsible for developing the employer group's premium~~  
437 ~~rates, or~~

438 (B) the department determines that compliance with this section is not required under  
439 the provisions of Subsection (3) [~~or (4)~~].

440 (b) An employee has a private right of action only against the employee's employer to  
441 enforce the provisions of this Subsection (7).

442 (8) Any penalties imposed and collected under this section shall be deposited into the  
443 Medicaid Restricted Account created in Section [26-18-402](#).

444 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
445 coverage as required by this section:

446 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
447 or contractor under:

448 (i) Section [63G-6a-1602](#); or

449 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

450 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
451 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
452 or construction.

453 Section 3. Section **26-18-402** is amended to read:

454 **26-18-402. Medicaid Restricted Account.**

455 (1) There is created a restricted account in the General Fund known as the Medicaid  
456 Restricted Account.

457 (2) (a) Except as provided in Subsection (3), the following shall be deposited into the  
458 Medicaid Restricted Account:

459 (i) any general funds appropriated to the department for the state plan for medical

460 assistance or for the Division of Health Care Financing that are not expended by the  
461 department in the fiscal year for which the general funds were appropriated and which are not  
462 otherwise designated as nonlapsing shall lapse into the Medicaid Restricted Account;

463 (ii) any unused state funds that are associated with the Medicaid program, as defined in  
464 Section [26-18-2](#), from the Department of Workforce Services and the Department of Human  
465 Services; and

466 (iii) any penalties imposed and collected under:

467 (A) Section [17B-2a-818.5](#);

468 (B) Section [19-1-206](#);

469 [~~(C) Section [63A-5-205](#);~~]

470 (C) Subsection [63A-5-205.5](#);

471 (D) Section [63C-9-403](#);

472 (E) Section [72-6-107.5](#); or

473 (F) Section [79-2-404](#).

474 (b) The account shall earn interest and all interest earned shall be deposited into the  
475 account.

476 (c) The Legislature may appropriate money in the restricted account to fund programs  
477 that expand medical assistance coverage and private health insurance plans to low income  
478 persons who have not traditionally been served by Medicaid, including the Utah Children's  
479 Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act.

480 (3) For fiscal years 2008-09, 2009-10, 2010-11, 2011-12, and 2012-13 the following  
481 funds are nonlapsing:

482 (a) any general funds appropriated to the department for the state plan for medical  
483 assistance, or for the Division of Health Care Financing that are not expended by the  
484 department in the fiscal year in which the general funds were appropriated; and

485 (b) funds described in Subsection (2)(a)(ii).

486 Section 4. Section **26-40-115** is amended to read:

487 **26-40-115. State contractor -- Employee and dependent health benefit plan**  
488 **coverage.**

489 (1) For purposes of Sections [17B-2a-818.5](#), [19-1-206](#), [~~[63A-5-205](#)~~] [63A-5-205.5](#),  
490 [63C-9-403](#), [72-6-107.5](#), and [79-2-404](#), "qualified health insurance coverage" means, at the time

491 the contract is entered into or renewed:

492 (a) a health benefit plan and employer contribution level with a combined actuarial  
493 value at least actuarially equivalent to the combined actuarial value of the benchmark plan  
494 determined by the program under Subsection 26-40-106(1), and a contribution level at which  
495 the employer pays at least 50% of the premium for the employee and the dependents of the  
496 employee who reside or work in the state; or

497 (b) a federally qualified high deductible health plan that, at a minimum:

498 (i) has a deductible that is:

499 (A) the lowest deductible permitted for a federally qualified high deductible health  
500 plan; or

501 (B) a deductible that is higher than the lowest deductible permitted for a federally  
502 qualified high deductible health plan, but includes an employer contribution to a health savings  
503 account in a dollar amount at least equal to the dollar amount difference between the lowest  
504 deductible permitted for a federally qualified high deductible plan and the deductible for the  
505 employer offered federally qualified high deductible plan;

506 (ii) has an out-of-pocket maximum that does not exceed three times the amount of the  
507 annual deductible; and

508 (iii) provides that the employer pays 60% of the premium for the employee and the  
509 dependents of the employee who work or reside in the state.

510 (2) The department shall:

511 (a) on or before July 1, 2016:

512 (i) determine the commercial equivalent of the benchmark plan described in Subsection  
513 (1)(a); and

514 (ii) post the commercially equivalent benchmark plan described in Subsection (2)(a)(i)  
515 on the department's website, noting the date posted; and

516 (b) update the posted commercially equivalent benchmark plan annually and at the  
517 time of any change in the benchmark.

518 Section 5. Section 31A-1-301 is amended to read:

519 **31A-1-301. Definitions.**

520 As used in this title, unless otherwise specified:

521 (1) (a) "Accident and health insurance" means insurance to provide protection against

522 economic losses resulting from:

523 (i) a medical condition including:

524 (A) a medical care expense; or

525 (B) the risk of disability;

526 (ii) accident; or

527 (iii) sickness.

528 (b) "Accident and health insurance":

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

530 (A) an income replacement contract;

531 (B) a health care contract;

532 (C) an expense reimbursement contract;

533 (D) a credit accident and health contract;

534 (E) a continuing care contract; and

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

536 (ii) may provide:

537 (A) hospital coverage;

538 (B) surgical coverage;

539 (C) medical coverage;

540 (D) loss of income coverage;

541 (E) prescription drug coverage;

542 (F) dental coverage; or

543 (G) vision coverage.

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

545 (d) For purposes of a national licensing registry, "accident and health insurance" is the  
546 same as "accident and health or sickness insurance."

547 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title  
548 63G, Chapter 3, Utah Administrative Rulemaking Act.

549 (3) "Administrator" means the same as that term is defined in Subsection ~~[(+70)]~~ (171).

550 (4) "Adult" means an individual who has attained the age of at least 18 years.

551 (5) "Affiliate" means a person who controls, is controlled by, or is under common

552 control with, another person. A corporation is an affiliate of another corporation, regardless of

553 ownership, if substantially the same group of individuals manage the corporations.

554 (6) "Agency" means:

555 (a) a person other than an individual, including a sole proprietorship by which an  
556 individual does business under an assumed name; and

557 (b) an insurance organization licensed or required to be licensed under Section  
558 [31A-23a-301](#), [31A-25-207](#), or [31A-26-209](#).

559 (7) "Alien insurer" means an insurer domiciled outside the United States.

560 (8) "Amendment" means an endorsement to an insurance policy or certificate.

561 (9) "Annuity" means an agreement to make periodical payments for a period certain or  
562 over the lifetime of one or more individuals if the making or continuance of all or some of the  
563 series of the payments, or the amount of the payment, is dependent upon the continuance of  
564 human life.

565 (10) "Application" means a document:

566 (a) (i) completed by an applicant to provide information about the risk to be insured;

567 and

568 (ii) that contains information that is used by the insurer to evaluate risk and decide  
569 whether to:

570 (A) insure the risk under:

571 (I) the coverage as originally offered; or

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

573 (B) decline to insure the risk; or

574 (b) used by the insurer to gather information from the applicant before issuance of an  
575 annuity contract.

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

577 (a) the original articles;

578 (b) a special law;

579 (c) a charter;

580 (d) an amendment;

581 (e) restated articles;

582 (f) articles of merger or consolidation;

583 (g) a trust instrument;

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

585 and

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

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

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

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

593 (a) without individual underwriting or application; and

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

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

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

598 (a) that is open to the public;

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

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

601 (17) "Business entity" means:

602 (a) a corporation;

603 (b) an association;

604 (c) a partnership;

605 (d) a limited liability company;

606 (e) a limited liability partnership; or

607 (f) another legal entity.

608 (18) "Business of insurance" means the same as that term is defined in Subsection  
609 [~~91~~] (92).

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

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

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

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

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

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

620 (21) "Captive insurance company" means:

621 (a) an insurer:

622 (i) owned by another organization; and

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

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

626 (i) owned by the insureds; and

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

628 (A) a member organization;

629 (B) a group member; or

630 (C) an affiliate of:

631 (I) a member organization; or

632 (II) a group member.

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

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

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

636 (b) a third party.

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

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

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

643 (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance  
644 commissioner.

645 (b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent

646 supervisory official of another jurisdiction.

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

648 (i) provides board and lodging;

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

650 (A) a personal service;

651 (B) a nursing service;

652 (C) a medical service; or

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

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

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

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

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

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

663 (i) by contract;

664 (ii) by common management;

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

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

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

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

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

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

676 (31) "Controlling person" means a person that directly or indirectly has the power to

677 direct or cause to be directed, the management, control, or activities of a reinsurance  
678 intermediary.

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

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

682 (i) a corporation doing business:

683 (A) as:

684 (I) an insurance producer;

685 (II) a surplus lines producer;

686 (III) a limited line producer;

687 (IV) a consultant;

688 (V) a managing general agent;

689 (VI) a reinsurance intermediary;

690 (VII) a third party administrator; or

691 (VIII) an adjuster; and

692 (B) under:

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

694 Reinsurance Intermediaries;

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

696 (III) Chapter 26, Insurance Adjusters; or

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

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

700 (c) "Stock corporation" means a stock insurance corporation.

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

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

705 (i) the Primary Care Network Program under a Medicaid primary care network  
706 demonstration waiver obtained subject to Section [26-18-3](#);

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

708 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.  
709 No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No.  
710 109-415.

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

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

716 (b) "Credit insurance" includes:

- 717 (i) credit accident and health insurance;
- 718 (ii) credit life insurance;
- 719 (iii) credit property insurance;
- 720 (iv) credit unemployment insurance;
- 721 (v) guaranteed automobile protection insurance;
- 722 (vi) involuntary unemployment insurance;
- 723 (vii) mortgage accident and health insurance;
- 724 (viii) mortgage guaranty insurance; and
- 725 (ix) mortgage life insurance.

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

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

- 729 (a) matured;
- 730 (b) unmatured;
- 731 (c) liquidated;
- 732 (d) unliquidated;
- 733 (e) secured;
- 734 (f) unsecured;
- 735 (g) absolute;
- 736 (h) fixed; or
- 737 (i) contingent.

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

- 739 (a) offered in connection with an extension of credit; and  
740 (b) that protects the property until the debt is paid.
- 741 (40) "Credit unemployment insurance" means insurance:  
742 (a) offered in connection with an extension of credit; and  
743 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:  
744 (i) specific loan; or  
745 (ii) credit transaction.
- 746 (41) (a) "Crop insurance" means insurance providing protection against damage to  
747 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,  
748 disease, or other yield-reducing conditions or perils that is:  
749 (i) provided by the private insurance market; or  
750 (ii) subsidized by the Federal Crop Insurance Corporation.
- 751 (b) "Crop insurance" includes multiperil crop insurance.
- 752 (42) (a) "Customer service representative" means a person that provides an insurance  
753 service and insurance product information:  
754 (i) for the customer service representative's:  
755 (A) producer;  
756 (B) surplus lines producer; or  
757 (C) consultant employer; and  
758 (ii) to the customer service representative's employer's:  
759 (A) customer;  
760 (B) client; or  
761 (C) organization.
- 762 (b) A customer service representative may only operate within the scope of authority of  
763 the customer service representative's producer, surplus lines producer, or consultant employer.
- 764 (43) "Deadline" means a final date or time:  
765 (a) imposed by:  
766 (i) statute;  
767 (ii) rule; or  
768 (iii) order; and  
769 (b) by which a required filing or payment must be received by the department.

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

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

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

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

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

781 (a) perform the duties of:

782 (i) that individual's occupation; or

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

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

786 (i) eating;

787 (ii) toileting;

788 (iii) transferring;

789 (iv) bathing; or

790 (v) dressing.

791 (49) "Disability income insurance" means the same as that term is defined in  
792 Subsection [~~(82)~~] (83).

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

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

795 (a) is incorporated;

796 (b) is organized; or

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

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

799 (i) an employee who:

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

- 801 (B) has a normal work week of 30 or more hours; or
- 802 (ii) a person described in Subsection (52)(b).
- 803 (b) "Eligible employee" includes:
- 804 (i) an owner who:
- 805 (A) works on a full-time basis; and
- 806 (B) has a normal work week of 30 or more hours; and
- 807 (ii) if the individual is included under a health benefit plan of a small employer:
- 808 (A) a sole proprietor;
- 809 (B) a partner in a partnership; or
- 810 (C) an independent contractor.
- 811 (c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):
- 812 (i) an individual who works on a temporary or substitute basis for a small employer;
- 813 (ii) an employer's spouse who does not meet the requirements of Subsection (52)(a)(i);
- 814 or
- 815 (iii) a dependent of an employer who does not meet the requirements of Subsection
- 816 (52)(a)(i).
- 817 (53) "Employee" means:
- 818 (a) an individual employed by an employer; and
- 819 (b) an owner who meets the requirements of Subsection (52)(b)(i).
- 820 (54) "Employee benefits" means one or more benefits or services provided to:
- 821 (a) an employee; or
- 822 (b) a dependent of an employee.
- 823 (55) (a) "Employee welfare fund" means a fund:
- 824 (i) established or maintained, whether directly or through a trustee, by:
- 825 (A) one or more employers;
- 826 (B) one or more labor organizations; or
- 827 (C) a combination of employers and labor organizations; and
- 828 (ii) that provides employee benefits paid or contracted to be paid, other than income
- 829 from investments of the fund:
- 830 (A) by or on behalf of an employer doing business in this state; or
- 831 (B) for the benefit of a person employed in this state.

832 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax  
833 revenues.

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

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

837 (i) a policyholder;

838 (ii) a certificate holder;

839 (iii) a subscriber; or

840 (iv) a covered individual:

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

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

843 (b) "Enrollee" includes an insured.

844 (58) "Enrollment date," with respect to a health benefit plan, means:

845 (a) the first day of coverage; or

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

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

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

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

854 (60) (a) "Escrow" means:

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

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

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

861 (ii) a settlement or closing involving:

862 (A) a mobile home;

- 863 (B) a grazing right;
- 864 (C) a water right; or
- 865 (D) other personal property authorized by the commissioner.
- 866 (b) "Escrow" does not include:
- 867 (i) the following notarial acts performed by a notary within the state:
- 868 (A) an acknowledgment;
- 869 (B) a copy certification;
- 870 (C) jurat; and
- 871 (D) an oath or affirmation;
- 872 (ii) the receipt or delivery of a document; or
- 873 (iii) the receipt of money for delivery to the escrow agent.
- 874 (61) "Escrow agent" means an agency title insurance producer meeting the
- 875 requirements of Sections [31A-4-107](#), [31A-14-211](#), and [31A-23a-204](#), who is acting through an
- 876 individual title insurance producer licensed with an escrow subline of authority.
- 877 (62) (a) "Excludes" is not exhaustive and does not mean that another thing is not also
- 878 excluded.
- 879 (b) The items listed in a list using the term "excludes" are representative examples for
- 880 use in interpretation of this title.
- 881 (63) "Exclusion" means for the purposes of accident and health insurance that an
- 882 insurer does not provide insurance coverage, for whatever reason, for one of the following:
- 883 (a) a specific physical condition;
- 884 (b) a specific medical procedure;
- 885 (c) a specific disease or disorder; or
- 886 (d) a specific prescription drug or class of prescription drugs.
- 887 (64) "Expense reimbursement insurance" means insurance:
- 888 (a) written to provide a payment for an expense relating to hospital confinement
- 889 resulting from illness or injury; and
- 890 (b) written:
- 891 (i) as a daily limit for a specific number of days in a hospital; and
- 892 (ii) to have a one or two day waiting period following a hospitalization.
- 893 (65) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding

894 a position of public or private trust.

895 (66) (a) "Filed" means that a filing is:

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

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

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

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

902 (B) rule.

903 (b) "Filed" does not include a filing that is rejected by the department because it is not  
904 submitted in accordance with Subsection (66)(a).

905 (67) "Filing," when used as a noun, means an item required to be filed with the  
906 department including:

907 (a) a policy;

908 (b) a rate;

909 (c) a form;

910 (d) a document;

911 (e) a plan;

912 (f) a manual;

913 (g) an application;

914 (h) a report;

915 (i) a certificate;

916 (j) an endorsement;

917 (k) an actuarial certification;

918 (l) a licensee annual statement;

919 (m) a licensee renewal application;

920 (n) an advertisement;

921 (o) a binder; or

922 (p) an outline of coverage.

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

925 (69) "Foreign insurer" means an insurer domiciled outside of this state, including an  
926 alien insurer.

927 (70) (a) "Form" means one of the following prepared for general use:

928 (i) a policy;

929 (ii) a certificate;

930 (iii) an application;

931 (iv) an outline of coverage; or

932 (v) an endorsement.

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

935 (71) "Franchise insurance" means an individual insurance policy provided through a  
936 mass marketing arrangement involving a defined class of persons related in some way other  
937 than through the purchase of insurance.

938 (72) "General lines of authority" include:

939 (a) the general lines of insurance in Subsection (73);

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

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

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

943 (iii) title marketing representative only;

944 (c) surplus lines;

945 (d) workers' compensation; and

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

948 (73) "General lines of insurance" include:

949 (a) accident and health;

950 (b) casualty;

951 (c) life;

952 (d) personal lines;

953 (e) property; and

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

955 (74) "Group health plan" means an employee welfare benefit plan to the extent that the

956 plan provides medical care:

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

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

959 (b) (i) directly;

960 (ii) through insurance reimbursement; or

961 (iii) through another method.

962 (75) (a) "Group insurance policy" means a policy covering a group of persons that is  
963 issued:

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

965 (ii) for the benefit of a member of the group who is selected under a procedure defined  
966 in:

967 (A) the policy; or

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

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

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

974 (77) (a) "Health benefit plan" means, except as provided in Subsection (77)(b), a  
975 policy, contract, certificate, or agreement offered or issued by a health carrier to provide,  
976 deliver, arrange for, pay for, or reimburse any of the costs of health care.

977 (b) "Health benefit plan" does not include:

978 (i) coverage only for accident or disability income insurance, or any combination  
979 thereof;

980 (ii) coverage issued as a supplement to liability insurance;

981 (iii) liability insurance, including general liability insurance and automobile liability  
982 insurance;

983 (iv) workers' compensation or similar insurance;

984 (v) automobile medical payment insurance;

985 (vi) credit-only insurance;

986 (vii) coverage for on-site medical clinics;

987 (viii) other similar insurance coverage, specified in federal regulations issued pursuant  
988 to Pub. L. No. 104-191, under which benefits for health care services are secondary or  
989 incidental to other insurance benefits;

990 (ix) the following benefits if they are provided under a separate policy, certificate, or  
991 contract of insurance or are otherwise not an integral part of the plan:

992 (A) limited scope dental or vision benefits;

993 (B) benefits for long-term care, nursing home care, home health care,  
994 community-based care, or any combination thereof; or

995 (C) other similar limited benefits, specified in federal regulations issued pursuant to  
996 Pub. L. No. 104-191;

997 (x) the following benefits if the benefits are provided under a separate policy,  
998 certificate, or contract of insurance, there is no coordination between the provision of benefits  
999 and any exclusion of benefits under any health plan, and the benefits are paid with respect to an  
1000 event without regard to whether benefits are provided under any health plan:

1001 (A) coverage only for specified disease or illness; or

1002 (B) hospital indemnity or other fixed indemnity insurance; and

1003 (xi) the following if offered as a separate policy, certificate, or contract of insurance:

1004 (A) Medicare supplemental health insurance as defined under the Social Security Act,  
1005 42 U.S.C. Sec. 1395ss(g)(1);

1006 (B) coverage supplemental to the coverage provided under United States Code, Title  
1007 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services  
1008 (CHAMPUS); or

1009 (C) similar supplemental coverage provided to coverage under a group health insurance  
1010 plan.

1011 (78) "Health care" means any of the following intended for use in the diagnosis,  
1012 treatment, mitigation, or prevention of a human ailment or impairment:

1013 (a) a professional service;

1014 (b) a personal service;

1015 (c) a facility;

1016 (d) equipment;

1017 (e) a device;

1018 (f) supplies; or  
1019 (g) medicine.  
1020 (79) (a) "Health care insurance" or "health insurance" means insurance providing:  
1021 (i) a health care benefit; or  
1022 (ii) payment of an incurred health care expense.  
1023 (b) "Health care insurance" or "health insurance" does not include accident and health  
1024 insurance providing a benefit for:  
1025 (i) replacement of income;  
1026 (ii) short-term accident;  
1027 (iii) fixed indemnity;  
1028 (iv) credit accident and health;  
1029 (v) supplements to liability;  
1030 (vi) workers' compensation;  
1031 (vii) automobile medical payment;  
1032 (viii) no-fault automobile;  
1033 (ix) equivalent self-insurance; or  
1034 (x) a type of accident and health insurance coverage that is a part of or attached to  
1035 another type of policy.  
1036 (80) "Health care provider" means the same as that term is defined in Section  
1037 [78B-3-403](#).  
1038 (81) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec.  
1039 155.20.  
1040 ~~[(81)]~~ (82) "Health Insurance Portability and Accountability Act" means the Health  
1041 Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as  
1042 amended.  
1043 ~~[(82)]~~ (83) "Income replacement insurance" or "disability income insurance" means  
1044 insurance written to provide payments to replace income lost from accident or sickness.  
1045 ~~[(83)]~~ (84) "Indemnity" means the payment of an amount to offset all or part of an  
1046 insured loss.  
1047 ~~[(84)]~~ (85) "Independent adjuster" means an insurance adjuster required to be licensed  
1048 under Section [31A-26-201](#) who engages in insurance adjusting as a representative of an insurer.

- 1049           ~~[(85)]~~ (86) "Independently procured insurance" means insurance procured under  
1050 Section [31A-15-104](#).
- 1051           ~~[(86)]~~ (87) "Individual" means a natural person.
- 1052           ~~[(87)]~~ (88) "Inland marine insurance" includes insurance covering:
- 1053           (a) property in transit on or over land;
- 1054           (b) property in transit over water by means other than boat or ship;
- 1055           (c) bailee liability;
- 1056           (d) fixed transportation property such as bridges, electric transmission systems, radio  
1057 and television transmission towers and tunnels; and
- 1058           (e) personal and commercial property floaters.
- 1059           ~~[(88)]~~ (89) "Insolvency" or "insolvent" means that:
- 1060           (a) an insurer is unable to pay ~~[its debts or meet its obligations as the debts and~~  
1061 ~~obligations mature]~~ the insurer's obligations as the obligations are due;
- 1062           (b) an insurer's total adjusted capital is less than the insurer's mandatory control level  
1063 RBC under Subsection [31A-17-601](#)(8)(c); or
- 1064           (c) an ~~[insurer is determined to be hazardous under this title]~~ insurer's admitted assets  
1065 are less than the insurer's liabilities.
- 1066           ~~[(89)]~~ (90) (a) "Insurance" means:
- 1067           (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more  
1068 persons to one or more other persons; or
- 1069           (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a  
1070 group of persons that includes the person seeking to distribute that person's risk.
- 1071           (b) "Insurance" includes:
- 1072           (i) a risk distributing arrangement providing for compensation or replacement for  
1073 damages or loss through the provision of a service or a benefit in kind;
- 1074           (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a  
1075 business and not as merely incidental to a business transaction; and
- 1076           (iii) a plan in which the risk does not rest upon the person who makes an arrangement,  
1077 but with a class of persons who have agreed to share the risk.
- 1078           ~~[(90)]~~ (91) "Insurance adjuster" means a person who directs or conducts the  
1079 investigation, negotiation, or settlement of a claim under an insurance policy other than life

1080 insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance  
1081 policy.

1082 ~~[(91)]~~ (92) "Insurance business" or "business of insurance" includes:

1083 (a) providing health care insurance by an organization that is or is required to be  
1084 licensed under this title;

1085 (b) providing a benefit to an employee in the event of a contingency not within the  
1086 control of the employee, in which the employee is entitled to the benefit as a right, which  
1087 benefit may be provided either:

1088 (i) by a single employer or by multiple employer groups; or

1089 (ii) through one or more trusts, associations, or other entities;

1090 (c) providing an annuity:

1091 (i) including an annuity issued in return for a gift; and

1092 (ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2)  
1093 and (3);

1094 (d) providing the characteristic services of a motor club as outlined in Subsection  
1095 ~~[(120)]~~ (121);

1096 (e) providing another person with insurance;

1097 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,  
1098 or surety, a contract or policy of title insurance;

1099 (g) transacting or proposing to transact any phase of title insurance, including:

1100 (i) solicitation;

1101 (ii) negotiation preliminary to execution;

1102 (iii) execution of a contract of title insurance;

1103 (iv) insuring; and

1104 (v) transacting matters subsequent to the execution of the contract and arising out of  
1105 the contract, including reinsurance;

1106 (h) transacting or proposing a life settlement; and

1107 (i) doing, or proposing to do, any business in substance equivalent to Subsections

1108 ~~[(91)]~~ (92)(a) through (h) in a manner designed to evade this title.

1109 ~~[(92)]~~ (93) "Insurance consultant" or "consultant" means a person who:

1110 (a) advises another person about insurance needs and coverages;

1111 (b) is compensated by the person advised on a basis not directly related to the insurance  
1112 placed; and

1113 (c) except as provided in Section 31A-23a-501, is not compensated directly or  
1114 indirectly by an insurer or producer for advice given.

1115 ~~[(93)]~~ (94) "Insurance holding company system" means a group of two or more  
1116 affiliated persons, at least one of whom is an insurer.

1117 ~~[(94)]~~ (95) (a) "Insurance producer" or "producer" means a person licensed or required  
1118 to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

1119 (b) (i) "Producer for the insurer" means a producer who is compensated directly or  
1120 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that  
1121 insurer.

1122 (ii) "Producer for the insurer" may be referred to as an "agent."

1123 (c) (i) "Producer for the insured" means a producer who:

1124 (A) is compensated directly and only by an insurance customer or an insured; and

1125 (B) receives no compensation directly or indirectly from an insurer for selling,  
1126 soliciting, or negotiating an insurance product of that insurer to an insurance customer or  
1127 insured.

1128 (ii) "Producer for the insured" may be referred to as a "broker."

1129 ~~[(95)]~~ (96) (a) "Insured" means a person to whom or for whose benefit an insurer  
1130 makes a promise in an insurance policy and includes:

1131 (i) a policyholder;

1132 (ii) a subscriber;

1133 (iii) a member; and

1134 (iv) a beneficiary.

1135 (b) The definition in Subsection ~~[(95)]~~ (96)(a):

1136 (i) applies only to this title;

1137 (ii) does not define the meaning of "insured" as used in an insurance policy or  
1138 certificate; and

1139 (iii) includes an enrollee.

1140 ~~[(96)]~~ (97) (a) "Insurer" means a person [doing an insurance business as a principal  
1141 including:

- 1142 (i) a fraternal benefit society;
- 1143 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
- 1144 [31A-22-1305](#)(2) and (3);
- 1145 (iii) a motor club;
- 1146 (iv) an employee welfare plan;
- 1147 (v) a person purporting or intending to do an insurance business as a principal on that
- 1148 person's own account; and
- 1149 (vi) a health maintenance organization.
- 1150 (b) "Insurer" does not include a governmental entity to the extent the governmental
- 1151 entity is engaged in an activity described in Section [31A-12-107](#).
- 1152 [~~(97)~~] [\(98\)](#) "Interinsurance exchange" means the same as that term is defined in
- 1153 Subsection [~~(152)~~] [\(153\)](#).
- 1154 [~~(98)~~] [\(99\)](#) "Involuntary unemployment insurance" means insurance:
- 1155 (a) offered in connection with an extension of credit; and
- 1156 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
- 1157 coming due on a:
- 1158 (i) specific loan; or
- 1159 (ii) credit transaction.
- 1160 [~~(99)~~] [\(100\)](#) (a) "Large employer," in connection with a health benefit plan, means an
- 1161 employer who, with respect to a calendar year and to a plan year:
- 1162 (i) employed an average of at least 51 employees on business days during the preceding
- 1163 calendar year; and
- 1164 (ii) employs at least one employee on the first day of the plan year.
- 1165 (b) The number of employees shall be determined using the method set forth in 26
- 1166 U.S.C. Sec. 4980H(c)(2).
- 1167 [~~(100)~~] [\(101\)](#) "Late enrollee," with respect to an employer health benefit plan, means
- 1168 an individual whose enrollment is a late enrollment.
- 1169 [~~(101)~~] [\(102\)](#) "Late enrollment," with respect to an employer health benefit plan, means
- 1170 enrollment of an individual other than:
- 1171 (a) on the earliest date on which coverage can become effective for the individual
- 1172 under the terms of the plan; or

1173 (b) through special enrollment.

1174 [~~(102)~~] (103) (a) Except for a retainer contract or legal assistance described in Section  
1175 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a  
1176 specified legal expense.

1177 (b) "Legal expense insurance" includes an arrangement that creates a reasonable  
1178 expectation of an enforceable right.

1179 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,  
1180 legal services incidental to other insurance coverage.

1181 [~~(103)~~] (104) (a) "Liability insurance" means insurance against liability:

1182 (i) for death, injury, or disability of a human being, or for damage to property,  
1183 exclusive of the coverages under:

1184 (A) medical malpractice insurance;

1185 (B) professional liability insurance; and

1186 (C) workers' compensation insurance;

1187 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the

1188 insured who is injured, irrespective of legal liability of the insured, when issued with or

1189 supplemental to insurance against legal liability for the death, injury, or disability of a human

1190 being, exclusive of the coverages under:

1191 (A) medical malpractice insurance;

1192 (B) professional liability insurance; and

1193 (C) workers' compensation insurance;

1194 (iii) for loss or damage to property resulting from an accident to or explosion of a

1195 boiler, pipe, pressure container, machinery, or apparatus;

1196 (iv) for loss or damage to property caused by:

1197 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or

1198 (B) water entering through a leak or opening in a building; or

1199 (v) for other loss or damage properly the subject of insurance not within another kind

1200 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.

1201 (b) "Liability insurance" includes:

1202 (i) vehicle liability insurance;

1203 (ii) residential dwelling liability insurance; and

1204 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,  
1205 boiler, machinery, or apparatus of any kind when done in connection with insurance on the  
1206 elevator, boiler, machinery, or apparatus.

1207 [~~(104)~~] (105) (a) "License" means authorization issued by the commissioner to engage  
1208 in an activity that is part of or related to the insurance business.

1209 (b) "License" includes a certificate of authority issued to an insurer.

1210 [~~(105)~~] (106) (a) "Life insurance" means:

1211 (i) insurance on a human life; and

1212 (ii) insurance pertaining to or connected with human life.

1213 (b) The business of life insurance includes:

1214 (i) granting a death benefit;

1215 (ii) granting an annuity benefit;

1216 (iii) granting an endowment benefit;

1217 (iv) granting an additional benefit in the event of death by accident;

1218 (v) granting an additional benefit to safeguard the policy against lapse; and

1219 (vi) providing an optional method of settlement of proceeds.

1220 [~~(106)~~] (107) "Limited license" means a license that:

1221 (a) is issued for a specific product of insurance; and

1222 (b) limits an individual or agency to transact only for that product or insurance.

1223 [~~(107)~~] (108) "Limited line credit insurance" includes the following forms of  
1224 insurance:

1225 (a) credit life;

1226 (b) credit accident and health;

1227 (c) credit property;

1228 (d) credit unemployment;

1229 (e) involuntary unemployment;

1230 (f) mortgage life;

1231 (g) mortgage guaranty;

1232 (h) mortgage accident and health;

1233 (i) guaranteed automobile protection; and

1234 (j) another form of insurance offered in connection with an extension of credit that:

1235 (i) is limited to partially or wholly extinguishing the credit obligation; and  
1236 (ii) the commissioner determines by rule should be designated as a form of limited line  
1237 credit insurance.

1238 [~~(108)~~] (109) "Limited line credit insurance producer" means a person who sells,  
1239 solicits, or negotiates one or more forms of limited line credit insurance coverage to an  
1240 individual through a master, corporate, group, or individual policy.

1241 [~~(109)~~] (110) "Limited line insurance" includes:

- 1242 (a) bail bond;
- 1243 (b) limited line credit insurance;
- 1244 (c) legal expense insurance;
- 1245 (d) motor club insurance;
- 1246 (e) car rental related insurance;
- 1247 (f) travel insurance;
- 1248 (g) crop insurance;
- 1249 (h) self-service storage insurance;
- 1250 (i) guaranteed asset protection waiver;
- 1251 (j) portable electronics insurance; and
- 1252 (k) another form of limited insurance that the commissioner determines by rule should  
1253 be designated a form of limited line insurance.

1254 [~~(110)~~] (111) "Limited lines authority" includes the lines of insurance listed in  
1255 Subsection [~~(109)~~] (110).

1256 [~~(111)~~] (112) "Limited lines producer" means a person who sells, solicits, or negotiates  
1257 limited lines insurance.

1258 [~~(112)~~] (113) (a) "Long-term care insurance" means an insurance policy or rider  
1259 advertised, marketed, offered, or designated to provide coverage:

- 1260 (i) in a setting other than an acute care unit of a hospital;
- 1261 (ii) for not less than 12 consecutive months for a covered person on the basis of:
  - 1262 (A) expenses incurred;
  - 1263 (B) indemnity;
  - 1264 (C) prepayment; or
  - 1265 (D) another method;

- 1266 (iii) for one or more necessary or medically necessary services that are:
- 1267 (A) diagnostic;
- 1268 (B) preventative;
- 1269 (C) therapeutic;
- 1270 (D) rehabilitative;
- 1271 (E) maintenance; or
- 1272 (F) personal care; and
- 1273 (iv) that may be issued by:
- 1274 (A) an insurer;
- 1275 (B) a fraternal benefit society;
- 1276 (C) (I) a nonprofit health hospital; and
- 1277 (II) a medical service corporation;
- 1278 (D) a prepaid health plan;
- 1279 (E) a health maintenance organization; or
- 1280 (F) an entity similar to the entities described in Subsections [~~(112)~~] (113)(a)(iv)(A)
- 1281 through (E) to the extent that the entity is otherwise authorized to issue life or health care
- 1282 insurance.
- 1283 (b) "Long-term care insurance" includes:
- 1284 (i) any of the following that provide directly or supplement long-term care insurance:
- 1285 (A) a group or individual annuity or rider; or
- 1286 (B) a life insurance policy or rider;
- 1287 (ii) a policy or rider that provides for payment of benefits on the basis of:
- 1288 (A) cognitive impairment; or
- 1289 (B) functional capacity; or
- 1290 (iii) a qualified long-term care insurance contract.
- 1291 (c) "Long-term care insurance" does not include:
- 1292 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
- 1293 (ii) basic hospital expense coverage;
- 1294 (iii) basic medical/surgical expense coverage;
- 1295 (iv) hospital confinement indemnity coverage;
- 1296 (v) major medical expense coverage;

- 1297 (vi) income replacement or related asset-protection coverage;
- 1298 (vii) accident only coverage;
- 1299 (viii) coverage for a specified:
- 1300 (A) disease; or
- 1301 (B) accident;
- 1302 (ix) limited benefit health coverage; or
- 1303 (x) a life insurance policy that accelerates the death benefit to provide the option of a
- 1304 lump sum payment:
- 1305 (A) if the following are not conditioned on the receipt of long-term care:
- 1306 (I) benefits; or
- 1307 (II) eligibility; and
- 1308 (B) the coverage is for one or more the following qualifying events:
- 1309 (I) terminal illness;
- 1310 (II) medical conditions requiring extraordinary medical intervention; or
- 1311 (III) permanent institutional confinement.
- 1312 [~~(113)~~] (114) "Managed care organization" means a person:
- 1313 (a) licensed as a health maintenance organization under Chapter 8, Health Maintenance
- 1314 Organizations and Limited Health Plans; or
- 1315 (b) (i) licensed under:
- 1316 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
- 1317 (B) Chapter 7, Nonprofit Health Service Insurance Corporations; or
- 1318 (C) Chapter 14, Foreign Insurers; and
- 1319 (ii) that requires an enrollee to use, or offers incentives, including financial incentives,
- 1320 for an enrollee to use, network providers.
- 1321 [~~(114)~~] (115) "Medical malpractice insurance" means insurance against legal liability
- 1322 incident to the practice and provision of a medical service other than the practice and provision
- 1323 of a dental service.
- 1324 [~~(115)~~] (116) "Member" means a person having membership rights in an insurance
- 1325 corporation.
- 1326 [~~(116)~~] (117) "Minimum capital" or "minimum required capital" means the capital that
- 1327 must be constantly maintained by a stock insurance corporation as required by statute.

1328           ~~[(117)]~~ (118) "Mortgage accident and health insurance" means insurance offered in  
 1329 connection with an extension of credit that provides indemnity for payments coming due on a  
 1330 mortgage while the debtor has a disability.

1331           ~~[(118)]~~ (119) "Mortgage guaranty insurance" means surety insurance under which a  
 1332 mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

1333           ~~[(119)]~~ (120) "Mortgage life insurance" means insurance on the life of a debtor in  
 1334 connection with an extension of credit that pays if the debtor dies.

1335           ~~[(120)]~~ (121) "Motor club" means a person:

1336           (a) licensed under:

1337           (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

1338           (ii) Chapter 11, Motor Clubs; or

1339           (iii) Chapter 14, Foreign Insurers; and

1340           (b) that promises for an advance consideration to provide for a stated period of time

1341 one or more:

1342           (i) legal services under Subsection [31A-11-102\(1\)\(b\)](#);

1343           (ii) bail services under Subsection [31A-11-102\(1\)\(c\)](#); or

1344           (iii) (A) trip reimbursement;

1345           (B) towing services;

1346           (C) emergency road services;

1347           (D) stolen automobile services;

1348           (E) a combination of the services listed in Subsections ~~[(121)]~~ (121)(b)(iii)(A) through

1349 (D); or

1350           (F) other services given in Subsections [31A-11-102\(1\)\(b\)](#) through (f).

1351           ~~[(121)]~~ (122) "Mutual" means a mutual insurance corporation.

1352           ~~[(122)]~~ (123) "Network plan" means health care insurance:

1353           (a) that is issued by an insurer; and

1354           (b) under which the financing and delivery of medical care is provided, in whole or in  
 1355 part, through a defined set of providers under contract with the insurer, including the financing  
 1356 and delivery of an item paid for as medical care.

1357           ~~[(123)]~~ (124) "Network provider" means a health care provider who has an agreement  
 1358 with a managed care organization to provide health care services to an enrollee with an

1359 expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly  
1360 from the managed care organization.

1361 ~~[(124)]~~ (125) "Nonparticipating" means a plan of insurance under which the insured is  
1362 not entitled to receive a dividend representing a share of the surplus of the insurer.

1363 ~~[(125)]~~ (126) "Ocean marine insurance" means insurance against loss of or damage to:

1364 (a) ships or hulls of ships;

1365 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,  
1366 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia

1367 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

1368 (c) earnings such as freight, passage money, commissions, or profits derived from  
1369 transporting goods or people upon or across the oceans or inland waterways; or

1370 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,  
1371 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons  
1372 in connection with maritime activity.

1373 ~~[(126)]~~ (127) "Order" means an order of the commissioner.

1374 ~~[(127)]~~ (128) "Outline of coverage" means a summary that explains an accident and  
1375 health insurance policy.

1376 ~~[(128)]~~ (129) "Participating" means a plan of insurance under which the insured is  
1377 entitled to receive a dividend representing a share of the surplus of the insurer.

1378 ~~[(129)]~~ (130) "Participation," as used in a health benefit plan, means a requirement  
1379 relating to the minimum percentage of eligible employees that must be enrolled in relation to  
1380 the total number of eligible employees of an employer reduced by each eligible employee who  
1381 voluntarily declines coverage under the plan because the employee:

1382 (a) has other group health care insurance coverage; or

1383 (b) receives:

1384 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social  
1385 Security Amendments of 1965; or

1386 (ii) another government health benefit.

1387 ~~[(130)]~~ (131) "Person" includes:

1388 (a) an individual;

1389 (b) a partnership;

- 1390 (c) a corporation;
- 1391 (d) an incorporated or unincorporated association;
- 1392 (e) a joint stock company;
- 1393 (f) a trust;
- 1394 (g) a limited liability company;
- 1395 (h) a reciprocal;
- 1396 (i) a syndicate; or
- 1397 (j) another similar entity or combination of entities acting in concert.
- 1398 [~~(131)~~] (132) "Personal lines insurance" means property and casualty insurance
- 1399 coverage sold for primarily noncommercial purposes to:
- 1400 (a) an individual; or
- 1401 (b) a family.
- 1402 [~~(132)~~] (133) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec.
- 1403 1002(16)(B).
- 1404 [~~(133)~~] (134) "Plan year" means:
- 1405 (a) the year that is designated as the plan year in:
- 1406 (i) the plan document of a group health plan; or
- 1407 (ii) a summary plan description of a group health plan;
- 1408 (b) if the plan document or summary plan description does not designate a plan year or
- 1409 there is no plan document or summary plan description:
- 1410 (i) the year used to determine deductibles or limits;
- 1411 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;
- 1412 or
- 1413 (iii) the employer's taxable year if:
- 1414 (A) the plan does not impose deductibles or limits on a yearly basis; and
- 1415 (B) (I) the plan is not insured; or
- 1416 (II) the insurance policy is not renewed on an annual basis; or
- 1417 (c) in a case not described in Subsection [~~(133)~~] (134)(a) or (b), the calendar year.
- 1418 [~~(134)~~] (135) (a) "Policy" means a document, including an attached endorsement or
- 1419 application that:
- 1420 (i) purports to be an enforceable contract; and

- 1421 (ii) memorializes in writing some or all of the terms of an insurance contract.
- 1422 (b) "Policy" includes a service contract issued by:
- 1423 (i) a motor club under Chapter 11, Motor Clubs;
- 1424 (ii) a service contract provided under Chapter 6a, Service Contracts; and
- 1425 (iii) a corporation licensed under:
- 1426 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
- 1427 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
- 1428 (c) "Policy" does not include:
- 1429 (i) a certificate under a group insurance contract; or
- 1430 (ii) a document that does not purport to have legal effect.
- 1431 ~~[(135)]~~ (136) "Policyholder" means a person who controls a policy, binder, or oral
- 1432 contract by ownership, premium payment, or otherwise.
- 1433 ~~[(136)]~~ (137) "Policy illustration" means a presentation or depiction that includes
- 1434 nonguaranteed elements of a policy of life insurance over a period of years.
- 1435 ~~[(137)]~~ (138) "Policy summary" means a synopsis describing the elements of a life
- 1436 insurance policy.
- 1437 ~~[(138)]~~ (139) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L.
- 1438 No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152,
- 1439 and related federal regulations and guidance.
- 1440 ~~[(139)]~~ (140) "Preexisting condition," with respect to ~~[a health benefit plan]~~ health care
- 1441 insurance:
- 1442 (a) means a condition that was present before the effective date of coverage, whether or
- 1443 not medical advice, diagnosis, care, or treatment was recommended or received before that day;
- 1444 and
- 1445 (b) does not include a condition indicated by genetic information unless an actual
- 1446 diagnosis of the condition by a physician has been made.
- 1447 ~~[(140)]~~ (141) (a) "Premium" means the monetary consideration for an insurance policy.
- 1448 (b) "Premium" includes, however designated:
- 1449 (i) an assessment;
- 1450 (ii) a membership fee;
- 1451 (iii) a required contribution; or

- 1452 (iv) monetary consideration.
- 1453 (c) (i) "Premium" does not include consideration paid to a third party administrator for  
1454 the third party administrator's services.
- 1455 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for  
1456 insurance on the risks administered by the third party administrator.
- 1457 [~~(141)~~] (142) "Principal officers" for a corporation means the officers designated under  
1458 Subsection 31A-5-203(3).
- 1459 [~~(142)~~] (143) "Proceeding" includes an action or special statutory proceeding.
- 1460 [~~(143)~~] (144) "Professional liability insurance" means insurance against legal liability  
1461 incident to the practice of a profession and provision of a professional service.
- 1462 [~~(144)~~] (145) (a) Except as provided in Subsection [~~(144)~~] (145)(b), "property  
1463 insurance" means insurance against loss or damage to real or personal property of every kind  
1464 and any interest in that property:
- 1465 (i) from all hazards or causes; and
- 1466 (ii) against loss consequential upon the loss or damage including vehicle  
1467 comprehensive and vehicle physical damage coverages.
- 1468 (b) "Property insurance" does not include:
- 1469 (i) inland marine insurance; and
- 1470 (ii) ocean marine insurance.
- 1471 [~~(145)~~] (146) "Qualified long-term care insurance contract" or "federally tax qualified  
1472 long-term care insurance contract" means:
- 1473 (a) an individual or group insurance contract that meets the requirements of Section  
1474 7702B(b), Internal Revenue Code; or
- 1475 (b) the portion of a life insurance contract that provides long-term care insurance:
- 1476 (i) (A) by rider; or
- 1477 (B) as a part of the contract; and
- 1478 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue  
1479 Code.
- 1480 [~~(146)~~] (147) "Qualified United States financial institution" means an institution that:
- 1481 (a) is:
- 1482 (i) organized under the laws of the United States or any state; or

1483 (ii) in the case of a United States office of a foreign banking organization, licensed  
1484 under the laws of the United States or any state;

1485 (b) is regulated, supervised, and examined by a United States federal or state authority  
1486 having regulatory authority over a bank or trust company; and

1487 (c) meets the standards of financial condition and standing that are considered  
1488 necessary and appropriate to regulate the quality of a financial institution whose letters of credit  
1489 will be acceptable to the commissioner as determined by:

1490 (i) the commissioner by rule; or

1491 (ii) the Securities Valuation Office of the National Association of Insurance  
1492 Commissioners.

1493 [~~(147)~~] (148) (a) "Rate" means:

1494 (i) the cost of a given unit of insurance; or

1495 (ii) for property or casualty insurance, that cost of insurance per exposure unit either  
1496 expressed as:

1497 (A) a single number; or

1498 (B) a pure premium rate, adjusted before the application of individual risk variations  
1499 based on loss or expense considerations to account for the treatment of:

1500 (I) expenses;

1501 (II) profit; and

1502 (III) individual insurer variation in loss experience.

1503 (b) "Rate" does not include a minimum premium.

1504 [~~(148)~~] (149) (a) Except as provided in Subsection [~~(148)~~] (149)(b), "rate service  
1505 organization" means a person who assists an insurer in rate making or filing by:

1506 (i) collecting, compiling, and furnishing loss or expense statistics;

1507 (ii) recommending, making, or filing rates or supplementary rate information; or

1508 (iii) advising about rate questions, except as an attorney giving legal advice.

1509 (b) "Rate service organization" does not mean:

1510 (i) an employee of an insurer;

1511 (ii) a single insurer or group of insurers under common control;

1512 (iii) a joint underwriting group; or

1513 (iv) an individual serving as an actuarial or legal consultant.

1514            [~~(149)~~] (150) "Rating manual" means any of the following used to determine initial and  
1515 renewal policy premiums:

- 1516            (a) a manual of rates;
- 1517            (b) a classification;
- 1518            (c) a rate-related underwriting rule; and
- 1519            (d) a rating formula that describes steps, policies, and procedures for determining  
1520 initial and renewal policy premiums.

1521            [~~(150)~~] (151) (a) "Rebate" means a licensee paying, allowing, giving, or offering to  
1522 pay, allow, or give, directly or indirectly:

- 1523            (i) a refund of premium or portion of premium;
- 1524            (ii) a refund of commission or portion of commission;
- 1525            (iii) a refund of all or a portion of a consultant fee; or
- 1526            (iv) providing services or other benefits not specified in an insurance or annuity  
1527 contract.

1528            (b) "Rebate" does not include:

- 1529            (i) a refund due to termination or changes in coverage;
- 1530            (ii) a refund due to overcharges made in error by the licensee; or
- 1531            (iii) savings or wellness benefits as provided in the contract by the licensee.

1532            [~~(151)~~] (152) "Received by the department" means:

- 1533            (a) the date delivered to and stamped received by the department, if delivered in  
1534 person;
- 1535            (b) the post mark date, if delivered by mail;
- 1536            (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
- 1537            (d) the received date recorded on an item delivered, if delivered by:
  - 1538            (i) facsimile;
  - 1539            (ii) email; or
  - 1540            (iii) another electronic method; or
  - 1541            (e) a date specified in:
    - 1542            (i) a statute;
    - 1543            (ii) a rule; or
    - 1544            (iii) an order.

1545            [~~(152)~~] (153) "Reciprocal" or "interinsurance exchange" means an unincorporated  
1546 association of persons:

- 1547            (a) operating through an attorney-in-fact common to all of the persons; and
- 1548            (b) exchanging insurance contracts with one another that provide insurance coverage  
1549 on each other.

1550            [~~(153)~~] (154) "Reinsurance" means an insurance transaction where an insurer, for  
1551 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to  
1552 reinsurance transactions, this title sometimes refers to:

- 1553            (a) the insurer transferring the risk as the "ceding insurer"; and
- 1554            (b) the insurer assuming the risk as the:
  - 1555            (i) "assuming insurer"; or
  - 1556            (ii) "assuming reinsurer."

1557            [~~(154)~~] (155) "Reinsurer" means a person licensed in this state as an insurer with the  
1558 authority to assume reinsurance.

1559            [~~(155)~~] (156) "Residential dwelling liability insurance" means insurance against  
1560 liability resulting from or incident to the ownership, maintenance, or use of a residential  
1561 dwelling that is a detached single family residence or multifamily residence up to four units.

1562            [~~(156)~~] (157) (a) "Retrocession" means reinsurance with another insurer of a liability  
1563 assumed under a reinsurance contract.

1564            (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a  
1565 liability assumed under a reinsurance contract.

1566            [~~(157)~~] (158) "Rider" means an endorsement to:

- 1567            (a) an insurance policy; or
- 1568            (b) an insurance certificate.

1569            [~~(158)~~] (159) "Secondary medical condition" means a complication related to an  
1570 exclusion from coverage in accident and health insurance.

1571            [~~(159)~~] (160) (a) "Security" means a:

- 1572            (i) note;
- 1573            (ii) stock;
- 1574            (iii) bond;
- 1575            (iv) debenture;

- 1576 (v) evidence of indebtedness;
- 1577 (vi) certificate of interest or participation in a profit-sharing agreement;
- 1578 (vii) collateral-trust certificate;
- 1579 (viii) preorganization certificate or subscription;
- 1580 (ix) transferable share;
- 1581 (x) investment contract;
- 1582 (xi) voting trust certificate;
- 1583 (xii) certificate of deposit for a security;
- 1584 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
- 1585 payments out of production under such a title or lease;
- 1586 (xiv) commodity contract or commodity option;
- 1587 (xv) certificate of interest or participation in, temporary or interim certificate for,
- 1588 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
- 1589 in Subsections [~~(159)~~] (160)(a)(i) through (xiv); or
- 1590 (xvi) another interest or instrument commonly known as a security.
- 1591 (b) "Security" does not include:
- 1592 (i) any of the following under which an insurance company promises to pay money in a
- 1593 specific lump sum or periodically for life or some other specified period:
- 1594 (A) insurance;
- 1595 (B) an endowment policy; or
- 1596 (C) an annuity contract; or
- 1597 (ii) a burial certificate or burial contract.
- 1598 [~~(160)~~] (161) "Securityholder" means a specified person who owns a security of a
- 1599 person, including:
- 1600 (a) common stock;
- 1601 (b) preferred stock;
- 1602 (c) debt obligations; and
- 1603 (d) any other security convertible into or evidencing the right of any of the items listed
- 1604 in this Subsection [~~(160)~~] (161).
- 1605 [~~(161)~~] (162) (a) "Self-insurance" means an arrangement under which a person
- 1606 provides for spreading its own risks by a systematic plan.

1607 (b) Except as provided in this Subsection [~~(161)~~] (162), "self-insurance" does not  
1608 include an arrangement under which a number of persons spread their risks among themselves.

1609 (c) "Self-insurance" includes:

1610 (i) an arrangement by which a governmental entity undertakes to indemnify an  
1611 employee for liability arising out of the employee's employment; and

1612 (ii) an arrangement by which a person with a managed program of self-insurance and  
1613 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or  
1614 employees for liability or risk that is related to the relationship or employment.

1615 (d) "Self-insurance" does not include an arrangement with an independent contractor.

1616 [~~(162)~~] (163) "Sell" means to exchange a contract of insurance:

1617 (a) by any means;

1618 (b) for money or its equivalent; and

1619 (c) on behalf of an insurance company.

1620 [~~(163)~~] (164) "Short-term care insurance" means an insurance policy or rider  
1621 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care  
1622 insurance, but that provides coverage for less than 12 consecutive months for each covered  
1623 person.

1624 [~~(164)~~] (165) "Significant break in coverage" means a period of 63 consecutive days  
1625 during each of which an individual does not have creditable coverage.

1626 [~~(165)~~] (166) (a) "Small employer" means, in connection with a health benefit plan and  
1627 with respect to a calendar year and to a plan year, an employer who:

1628 (i) (A) employed at least one [~~employee~~] but not more than 50 eligible employees on  
1629 business days during the preceding calendar year; [~~and~~] or

1630 (B) if the employer did not exist for the entirety of the preceding calendar year,  
1631 reasonably expects to employ an average of at least one but not more than 50 eligible  
1632 employees on business days during the current calendar year;

1633 (ii) employs at least one employee on the first day of the plan year[-]; and

1634 [~~(b) The number of employees shall:~~]

1635 [~~(i) be determined using the method set forth in 26 U.S.C. Sec. 4980H(c)(2); and~~]

1636 [~~(ii) include an owner described in Subsection (52)(b)(i).]~~]

1637 (iii) for an employer who has common ownership with one or more other employers, is

1638 treated as a single employer under 26 U.S.C. Sec. 414(b), (c), (m), or (o).

1639 ~~[(e)]~~ (b) "Small employer" does not include a sole proprietor that does not employ at  
1640 least one employee.

1641 ~~[(166)]~~ (167) "Special enrollment period," in connection with a health benefit plan, has  
1642 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance  
1643 Portability and Accountability Act.

1644 ~~[(167)]~~ (168) (a) "Subsidiary" of a person means an affiliate controlled by that person  
1645 either directly or indirectly through one or more affiliates or intermediaries.

1646 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting  
1647 shares are owned by that person either alone or with its affiliates, except for the minimum  
1648 number of shares the law of the subsidiary's domicile requires to be owned by directors or  
1649 others.

1650 ~~[(168)]~~ (169) Subject to Subsection ~~[(89)]~~ (90)(b), "surety insurance" includes:

1651 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or  
1652 perform the principal's obligations to a creditor or other obligee;

1653 (b) bail bond insurance; and

1654 (c) fidelity insurance.

1655 ~~[(169)]~~ (170) (a) "Surplus" means the excess of assets over the sum of paid-in capital  
1656 and liabilities.

1657 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is  
1658 designated by the insurer or organization as permanent.

1659 (ii) Sections [31A-5-211](#), [31A-7-201](#), [31A-8-209](#), [31A-9-209](#), and [31A-14-205](#) require  
1660 that insurers or organizations doing business in this state maintain specified minimum levels of  
1661 permanent surplus.

1662 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the  
1663 same as the minimum required capital requirement that applies to stock insurers.

1664 (c) "Excess surplus" means:

1665 (i) for a life insurer, accident and health insurer, health organization, or property and  
1666 casualty insurer as defined in Section [31A-17-601](#), the lesser of:

1667 (A) that amount of an insurer's or health organization's total adjusted capital that  
1668 exceeds the product of:

1669 (I) 2.5; and  
1670 (II) the sum of the insurer's or health organization's minimum capital or permanent  
1671 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or  
1672 (B) that amount of an insurer's or health organization's total adjusted capital that  
1673 exceeds the product of:  
1674 (I) 3.0; and  
1675 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and  
1676 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer  
1677 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:  
1678 (A) 1.5; and  
1679 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).  
1680 [~~170~~] (171) "Third party administrator" or "administrator" means a person who  
1681 collects charges or premiums from, or who, for consideration, adjusts or settles claims of  
1682 residents of the state in connection with insurance coverage, annuities, or service insurance  
1683 coverage, except:  
1684 (a) a union on behalf of its members;  
1685 (b) a person administering a:  
1686 (i) pension plan subject to the federal Employee Retirement Income Security Act of  
1687 1974;  
1688 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or  
1689 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;  
1690 (c) an employer on behalf of the employer's employees or the employees of one or  
1691 more of the subsidiary or affiliated corporations of the employer;  
1692 (d) an insurer licensed under the following, but only for a line of insurance for which  
1693 the insurer holds a license in this state:  
1694 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;  
1695 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;  
1696 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;  
1697 (iv) Chapter 9, Insurance Fraternal; or  
1698 (v) Chapter 14, Foreign Insurers;  
1699 (e) a person:

- 1700 (i) licensed or exempt from licensing under:
- 1701 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
- 1702 Reinsurance Intermediaries; or
- 1703 (B) Chapter 26, Insurance Adjusters; and
- 1704 (ii) whose activities are limited to those authorized under the license the person holds
- 1705 or for which the person is exempt; or
- 1706 (f) an institution, bank, or financial institution:
- 1707 (i) that is:
- 1708 (A) an institution whose deposits and accounts are to any extent insured by a federal
- 1709 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
- 1710 Credit Union Administration; or
- 1711 (B) a bank or other financial institution that is subject to supervision or examination by
- 1712 a federal or state banking authority; and
- 1713 (ii) that does not adjust claims without a third party administrator license.
- 1714 ~~[(171)]~~ (172) "Title insurance" means the insuring, guaranteeing, or indemnifying of an
- 1715 owner of real or personal property or the holder of liens or encumbrances on that property, or
- 1716 others interested in the property against loss or damage suffered by reason of liens or
- 1717 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
- 1718 or unenforceability of any liens or encumbrances on the property.
- 1719 ~~[(172)]~~ (173) "Total adjusted capital" means the sum of an insurer's or health
- 1720 organization's statutory capital and surplus as determined in accordance with:
- 1721 (a) the statutory accounting applicable to the annual financial statements required to be
- 1722 filed under Section 31A-4-113; and
- 1723 (b) another item provided by the RBC instructions, as RBC instructions is defined in
- 1724 Section 31A-17-601.
- 1725 ~~[(173)]~~ (174) (a) "Trustee" means "director" when referring to the board of directors of
- 1726 a corporation.
- 1727 (b) "Trustee," when used in reference to an employee welfare fund, means an
- 1728 individual, firm, association, organization, joint stock company, or corporation, whether acting
- 1729 individually or jointly and whether designated by that name or any other, that is charged with
- 1730 or has the overall management of an employee welfare fund.

1731 ~~[(174)]~~ (175) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted  
1732 insurer" means an insurer:

1733 (i) not holding a valid certificate of authority to do an insurance business in this state;

1734 or

1735 (ii) transacting business not authorized by a valid certificate.

1736 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1737 (i) holding a valid certificate of authority to do an insurance business in this state; and

1738 (ii) transacting business as authorized by a valid certificate.

1739 ~~[(175)]~~ (176) "Underwrite" means the authority to accept or reject risk on behalf of the  
1740 insurer.

1741 ~~[(176)]~~ (177) "Vehicle liability insurance" means insurance against liability resulting  
1742 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a  
1743 vehicle comprehensive or vehicle physical damage coverage under Subsection ~~[(144)]~~ (145).

1744 ~~[(177)]~~ (178) "Voting security" means a security with voting rights, and includes a  
1745 security convertible into a security with a voting right associated with the security.

1746 ~~[(178)]~~ (179) "Waiting period" for a health benefit plan means the period that must  
1747 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of  
1748 the health benefit plan, can become effective.

1749 ~~[(179)]~~ (180) "Workers' compensation insurance" means:

1750 (a) insurance for indemnification of an employer against liability for compensation  
1751 based on:

1752 (i) a compensable accidental injury; and

1753 (ii) occupational disease disability;

1754 (b) employer's liability insurance incidental to workers' compensation insurance and  
1755 written in connection with workers' compensation insurance; and

1756 (c) insurance assuring to a person entitled to workers' compensation benefits the  
1757 compensation provided by law.

1758 Section 6. Section **31A-2-201.1** is amended to read:

1759 **31A-2-201.1. General filing requirements.**

1760 Except as otherwise provided in this title, the commissioner may set by rule made in  
1761 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specific

1762 requirements for filing any of the following required by this title:

1763 (1) a form;

1764 (2) a rate; [~~or~~]

1765 (3) a report[~~;~~]; or

1766 (4) a binder for a health benefit plan or dental policy.

1767 Section 7. Section **31A-2-201.2** is amended to read:

1768 **31A-2-201.2. Evaluation of health insurance market.**

1769 (1) Each year the commissioner shall:

1770 (a) conduct an evaluation of the state's health insurance market;

1771 (b) report the findings of the evaluation to the Health and Human Services Interim

1772 Committee before [~~October~~] December 1 of each year; and

1773 (c) publish the findings of the evaluation on the department website.

1774 (2) The evaluation required by this section shall:

1775 (a) analyze the effectiveness of the insurance regulations and statutes in promoting a

1776 healthy, competitive health insurance market that meets the needs of the state, and includes an

1777 analysis of:

1778 (i) the availability and marketing of individual and group products;

1779 (ii) rate changes;

1780 (iii) coverage and demographic changes;

1781 (iv) benefit trends;

1782 (v) market share changes; and

1783 (vi) accessibility;

1784 (b) assess complaint ratios and trends within the health insurance market, which

1785 assessment shall include complaint data from the Office of Consumer Health Assistance within

1786 the department;

1787 (c) contain recommendations for action to improve the overall effectiveness of the

1788 health insurance market, administrative rules, and statutes; and

1789 (d) include claims loss ratio data for each health insurance company doing business in

1790 the state.

1791 (3) When preparing the evaluation and report required by this section, the

1792 commissioner may seek the input of insurers, employers, insured persons, providers, and others

1793 with an interest in the health insurance market.

1794 (4) The commissioner may adopt administrative rules for the purpose of collecting the  
1795 data required by this section, taking into account the business confidentiality of the insurers.

1796 (5) Records submitted to the commissioner under this section shall be maintained by  
1797 the commissioner as protected records under Title 63G, Chapter 2, Government Records  
1798 Access and Management Act.

1799 Section 8. Section 31A-2-204 is amended to read:

1800 **31A-2-204. Conducting examinations.**

1801 (1) As used in this section, "work papers" means a record that is created or relied upon:

1802 (a) during the course of an examination conducted under Section 31A-2-203; or

1803 (b) in drafting an examination report.

1804 ~~(1)~~ (2) (a) For each examination under Section 31A-2-203, the commissioner shall  
1805 issue an order:

1806 (i) stating the scope of the examination; and

1807 (ii) designating the examiner in charge.

1808 (b) The commissioner need not give advance notice of an examination to an examinee.

1809 (c) The examiner in charge shall give the examinee a copy of the order issued under  
1810 this Subsection ~~(1)~~ (2).

1811 (d) (i) The commissioner may alter the scope or nature of an examination at any time  
1812 without advance notice to the examinee.

1813 (ii) If the commissioner amends an order described in this Subsection ~~(1)~~ (2), the  
1814 commissioner shall provide a copy of any amended order to the examinee.

1815 (e) Statements in the commissioner's examination order concerning examination scope  
1816 are for the examiner's guidance only.

1817 (f) Examining relevant matters not mentioned in an order issued under this Subsection  
1818 ~~(1)~~ (2) is not a violation of this title.

1819 ~~(2)~~ (3) The commissioner shall, whenever practicable, cooperate with the insurance  
1820 regulators of other states by conducting joint examinations of:

1821 (a) multistate insurers doing business in this state; or

1822 (b) other multistate licensees doing business in this state.

1823 ~~(3)~~ (4) An examiner authorized by the commissioner shall, when necessary to the

1824 purposes of the examination, have access at all reasonable hours to the premises and to any  
1825 books, records, files, securities, documents, or property of:

1826 (a) the examinee; and

1827 (b) any of the following if the premises, books, records, files, securities, documents, or  
1828 property relate to the affairs of the examinee:

1829 (i) an officer of the examinee;

1830 (ii) any other person who:

1831 (A) has executive authority over the examinee; or

1832 (B) is in charge of any segment of the examinee's affairs; or

1833 (iii) any affiliate of the examinee under Subsection 31A-2-203(1)(b).

1834 ~~[(4)]~~ (5) (a) The officers, employees, and agents of the examinee and of persons under  
1835 Subsection 31A-2-203(1)(b) shall comply with every reasonable request of the examiners for  
1836 assistance in any matter relating to the examination.

1837 (b) A person may not obstruct or interfere with the examination except by legal  
1838 process.

1839 ~~[(5)]~~ (6) If the commissioner finds the accounts or records to be inadequate for proper  
1840 examination of the condition and affairs of the examinee or improperly kept or posted, the  
1841 commissioner may employ experts to rewrite, post, or balance the accounts or records at the  
1842 expense of the examinee.

1843 ~~[(6)]~~ (7) (a) The examiner in charge of an examination shall make a report of the  
1844 examination no later than 60 days after the completion of the examination that shall include:

1845 (i) the information and analysis ordered under Subsection ~~[(1)]~~ (2); and

1846 (ii) the examiner's recommendations.

1847 (b) At the option of the examiner in charge, preparation of the report may include  
1848 conferences with the examinee or representatives of the examinee.

1849 (c) The report is confidential until the report becomes a public document under  
1850 Subsection ~~[(7)]~~ (8), except the commissioner may use information from the report as a basis  
1851 for action under Chapter 27a, Insurer Receivership Act.

1852 ~~[(7)]~~ (8) (a) The commissioner shall serve a copy of the examination report described  
1853 in Subsection ~~[(6)]~~ (7) upon the examinee.

1854 (b) Within 20 days after service, the examinee shall:

- 1855 (i) accept the examination report as written; or
- 1856 (ii) request agency action to modify the examination report.
- 1857 (c) The report is considered accepted under this Subsection [~~(7)~~] (8) if the examinee
- 1858 does not file a request for agency action to modify the report within 20 days after service of the
- 1859 report.
- 1860 (d) If the examination report is accepted:
- 1861 (i) the examination report immediately becomes a public document; and
- 1862 (ii) the commissioner shall distribute the examination report to all jurisdictions in
- 1863 which the examinee is authorized to do business.
- 1864 (e) (i) Any adjudicative proceeding held as a result of the examinee's request for
- 1865 agency action shall, upon the examinee's demand, be closed to the public, except that the
- 1866 commissioner need not exclude any participating examiner from this closed hearing.
- 1867 (ii) Within 20 days after the hearing held under this Subsection [~~(7)~~] (8)(e), the
- 1868 commissioner shall:
- 1869 (A) adopt the examination report with any necessary modifications; and
- 1870 (B) serve a copy of the adopted report upon the examinee.
- 1871 (iii) Unless the examinee seeks judicial relief, the adopted examination report:
- 1872 (A) shall become a public document 10 days after service; and
- 1873 (B) may be distributed as described in this section.
- 1874 (f) Notwithstanding Title 63G, Chapter 4, Administrative Procedures Act, to the extent
- 1875 that this section is in conflict with Title 63G, Chapter 4, Administrative Procedures Act, this
- 1876 section governs:
- 1877 (i) a request for agency action under this section; or
- 1878 (ii) adjudicative proceeding under this section.
- 1879 [~~(8)~~] (9) The examinee shall promptly furnish copies of the adopted examination report
- 1880 described in Subsection [~~(7)~~] (8) to each member of the examinee's board.
- 1881 [~~(9)~~] (10) After an examination report becomes a public document under Subsection
- 1882 [~~(7)~~] (8), the commissioner may furnish, without cost or at a reasonable price set under Section
- 1883 31A-3-103, a copy of the examination report to interested persons, including:
- 1884 (a) a member of the board of the examinee; or
- 1885 (b) one or more newspapers in this state.

1886 ~~[(10)]~~ (11) (a) In a proceeding by or against the examinee, or any officer or agent of the  
 1887 examinee, the examination report as adopted by the commissioner is admissible as evidence of  
 1888 the facts stated in the report.

1889 (b) In any proceeding commenced under Chapter 27a, Insurer Receivership Act, the  
 1890 examination report, whether adopted by the commissioner or not, is admissible as evidence of  
 1891 the facts stated in the examination report.

1892 (12) Work papers are protected records under Title 63G, Chapter 2, Government  
 1893 Records Access and Management Act.

1894 Section 9. Section **31A-2-403** is amended to read:

1895 **31A-2-403. Title and Escrow Commission created.**

1896 (1) (a) Subject to Subsection (1)(b), there is created within the department the Title and  
 1897 Escrow Commission that is comprised of five members appointed by the governor with the  
 1898 consent of the Senate as follows:

1899 (i) except as provided in Subsection (1)(c), two members shall be employees of a title  
 1900 insurer;

1901 (ii) two members shall:

1902 (A) be employees of a Utah agency title insurance producer;

1903 (B) be or have been licensed under the title insurance line of authority;

1904 (C) as of the day on which the member is appointed, be or have been licensed with the  
 1905 title examination or escrow subline of authority for at least five years; and

1906 (D) as of the day on which the member is appointed, not be from the same county as  
 1907 another member appointed under this Subsection (1)(a)(ii); and

1908 (iii) one member shall be a member of the general public from any county in the state.

1909 (b) No more than one commission member may be appointed from a single company  
 1910 or an affiliate or subsidiary of the company.

1911 (c) If the governor is unable to identify more than one individual who is an employee  
 1912 of a title insurer and willing to serve as a member of the commission, the commission shall  
 1913 include the following members in lieu of the members described in Subsection (1)(a)(i):

1914 (i) one member who is an employee of a title insurer; and

1915 (ii) one member who is an employee of a Utah agency title insurance producer.

1916 (2) (a) Subject to Subsection (2)(c), a commission member shall file with the

1917 commissioner a disclosure of any position of employment or ownership interest that the  
1918 commission member has with respect to a person that is subject to the jurisdiction of the  
1919 commissioner.

1920 (b) The disclosure statement required by this Subsection (2) shall be:

1921 (i) filed by no later than the day on which the person begins that person's appointment;  
1922 and

1923 (ii) amended when a significant change occurs in any matter required to be disclosed  
1924 under this Subsection (2).

1925 (c) A commission member is not required to disclose an ownership interest that the  
1926 commission member has if the ownership interest is in a publicly traded company or held as  
1927 part of a mutual fund, trust, or similar investment.

1928 (3) (a) Except as required by Subsection (3)(b), as terms of current commission  
1929 members expire, the governor shall appoint each new commission member to a four-year term  
1930 ending on June 30.

1931 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the  
1932 time of appointment, adjust the length of terms to ensure that the terms of the commission  
1933 members are staggered so that approximately half of the members appointed under Subsection  
1934 (1)(a)(i) and half of the members appointed under Subsection (1)(a)(ii) are appointed every two  
1935 years.

1936 (c) A commission member may not serve more than one consecutive term.

1937 (d) When a vacancy occurs in the membership for any reason, the governor, with the  
1938 consent of the Senate, shall appoint a replacement for the unexpired term.

1939 (e) Notwithstanding the other provisions of this Subsection (3), a commission member  
1940 serves until a successor is appointed by the governor with the consent of the Senate.

1941 (4) A commission member may not receive compensation or benefits for the  
1942 commission member's service, but may receive per diem and travel expenses in accordance  
1943 with:

1944 (a) Section [63A-3-106](#);

1945 (b) Section [63A-3-107](#); and

1946 (c) rules made by the Division of Finance pursuant to Sections [63A-3-106](#) and  
1947 [63A-3-107](#).

1948 (5) Members of the commission shall annually select one commission member to serve  
1949 as chair.

1950 (6) (a) The commission shall meet at least monthly. Notwithstanding Section  
1951 52-4-207, a commission member shall physically attend a regularly scheduled monthly meeting  
1952 of the commission and may not attend through electronic means. A commission member may  
1953 attend subcommittee meetings, emergency meetings, or other not regularly scheduled meetings  
1954 electronically in accordance with Section 52-4-207.

1955 (b) The commissioner may call additional meetings:

1956 (i) at the commissioner's discretion;

1957 (ii) upon the request of the chair of the commission; or

1958 (iii) upon the written request of three or more commission members.

1959 (c) (i) Three commission members constitute a quorum for the transaction of business.

1960 (ii) The action of a majority of the commission members when a quorum is present is  
1961 the action of the commission.

1962 (7) The commissioner shall staff the commission.

1963 Section 10. Section 31A-3-303 is amended to read:

1964 **31A-3-303. Payment of tax.**

1965 (1) (a) An insurer, the producers involved in the transaction, and the policyholder are  
1966 jointly and severally liable for the payment of the taxes required under Section 31A-3-301.

1967 (b) The policyholder's liability for payment of the premium tax under Section  
1968 31A-3-301 ends when the policyholder pays the tax to a producer or an insurer.

1969 (c) The insurer and the producers involved in the transaction are jointly and severally  
1970 liable for the payment of the additional tax required under Section 31A-3-302.

1971 (d) Except for the tax under Section 31A-3-302, the policyholder shall pay a tax under  
1972 this part and shall be billed specifically for the tax when billed for the premium.

1973 (e) Except for the tax imposed under Section 31A-3-302, absorption of the tax by the  
1974 producer or insurer is an unfair method of competition under Sections 31A-23a-402 and  
1975 31A-23a-402.5.

1976 (2) (a) The commissioner shall by rule prescribe accounting and reporting forms and  
1977 procedures for insurers, producers, and policyholders to use in determining the amount of taxes  
1978 owed under this part, and the manner and time of payment.

1979 (b) If a tax is not paid within the time prescribed under the commissioner's rule, a  
1980 penalty shall be imposed of 25% of the tax due, plus 1-1/2% per month from the time of  
1981 default until full payment of the tax.

1982 (3) Upon making a record of its actions, and upon reasonable cause shown, the  
1983 commissioner may waive, reduce, or compromise any of the penalties or interest imposed  
1984 under this part.

1985 ~~[(4) Subject to Section 31A-3-305, if a policy covers risks that are only partially~~  
1986 ~~located in this state, for computation of tax under this part the premium shall be reasonably~~  
1987 ~~allocated among the states on the basis of risk locations. However, the premiums with respect~~  
1988 ~~to surplus lines insurance received in this state by a surplus lines producer or charged on~~  
1989 ~~policies written or negotiated in or from this state are taxable in full under this part, subject to a~~  
1990 ~~credit for any tax actually paid in another state to the extent of a reasonable allocation on the~~  
1991 ~~basis of risk locations.]~~

1992 (4) When Utah is the home state, premiums for surplus lines insurance are taxable in  
1993 full.

1994 (5) Subject to Section 31A-3-305, the premium taxes collected under this part by a  
1995 producer or by an insurer are the property of this state.

1996 (6) If the property of a producer is seized under any process in a court in this state, or if  
1997 a producer's business is suspended by the action of creditors or put into the hands of an  
1998 assignee, receiver, or trustee, the taxes and penalties due this state under this part are preferred  
1999 claims and the state is to that extent a preferred creditor.

2000 Section 11. Section 31A-3-304 is amended to read:

2001 **31A-3-304. Annual fees -- Other taxes or fees prohibited -- Captive Insurance**  
2002 **Restricted Account.**

2003 (1) (a) A captive insurance company shall pay an annual fee imposed under this section  
2004 to obtain or renew a certificate of authority.

2005 (b) The commissioner shall:

2006 (i) determine the annual fee pursuant to Section 31A-3-103; and

2007 (ii) consider whether the annual fee is competitive with fees imposed by other states on  
2008 captive insurance companies.

2009 (2) A captive insurance company that fails to pay the fee required by this section is

2010 subject to the relevant sanctions of this title.

2011 (3) (a) A captive insurance company that pays one of the following fees is exempt from  
2012 Title 59, Chapter 7, Corporate Franchise and Income Taxes, and Title 59, Chapter 9, Taxation  
2013 of Admitted Insurers:

2014 (i) a fee under this section;

2015 (ii) a fee under Chapter 37, Captive Insurance Companies Act; or

2016 (iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company  
2017 Act.

2018 (b) The state or a county, city, or town within the state may not levy or collect an  
2019 occupation tax or other fee or charge not described in Subsections (3)(a)(i) through (iii) against  
2020 a captive insurance company.

2021 (c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115  
2022 against a captive insurance company.

2023 (4) A captive insurance company shall pay the fee imposed by this section to the  
2024 commissioner by June 1 of each year.

2025 (5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be  
2026 deposited into the Captive Insurance Restricted Account.

2027 (b) There is created in the General Fund a restricted account known as the "Captive  
2028 Insurance Restricted Account."

2029 (c) The Captive Insurance Restricted Account shall consist of the fees described in  
2030 Subsection (3)(a).

2031 (d) The commissioner shall administer the Captive Insurance Restricted Account.  
2032 Subject to appropriations by the Legislature, the commissioner shall use the money deposited  
2033 into the Captive Insurance Restricted Account to:

2034 (i) administer and enforce:

2035 (A) Chapter 37, Captive Insurance Companies Act; and

2036 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and

2037 (ii) promote the captive insurance industry in Utah.

2038 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,  
2039 except that at the end of each fiscal year, money received by the commissioner in excess of the  
2040 following shall be treated as free revenue in the General Fund:

2041 ~~[(i) for fiscal year 2015-2016, in excess of \$1,250,000;]~~

2042 ~~[(ii) for fiscal year 2016-2017, in excess of \$1,250,000; and]~~

2043 ~~[(iii)]~~ (i) for fiscal year 2017-2018 and subsequent fiscal years, in excess of

2044 \$1,850,000~~[-]; and~~

2045 (ii) for fiscal year 2018-2019 and subsequent fiscal years, in excess of \$1,600,000.

2046 Section 12. Section **31A-6a-101** is amended to read:

2047 **31A-6a-101. Definitions.**

2048 As used in this chapter:

2049 (1) (a) "Incidental cost" means a cost, incurred by a warranty holder in relation to a  
2050 vehicle protection product warranty, that is in addition to the cost of purchasing the warranty.

2051 (b) "Incidental cost" includes an insurance policy deductible, a rental vehicle charge,  
2052 the difference between the actual value of the stolen vehicle at the time of theft and the cost of  
2053 a replacement vehicle, sales tax, a registration fee, a transaction fee, a mechanical inspection  
2054 fee, or damage a theft causes to a vehicle.

2055 ~~[(+)]~~ (2) "Mechanical breakdown insurance" means a policy, contract, or agreement  
2056 issued by an insurance company that has complied with either Chapter 5, Domestic Stock and  
2057 Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, that undertakes to perform or  
2058 provide repair or replacement service on goods or property, or indemnification for repair or  
2059 replacement service, for the operational or structural failure of the goods or property due to a  
2060 defect in materials, workmanship, or normal wear and tear.

2061 ~~[(2)]~~ (3) "Nonmanufacturers' parts" means replacement parts not made for or by the  
2062 original manufacturer of the goods commonly referred to as "after market parts."

2063 ~~[(3)]~~ (4) (a) "Road hazard" means a hazard that is encountered while driving a motor  
2064 vehicle.

2065 (b) "Road hazard" includes potholes, rocks, wood debris, metal parts, glass, plastic,  
2066 curbs, or composite scraps.

2067 ~~[(4)]~~ (5) (a) "Service contract" means a contract or agreement to perform or reimburse  
2068 for the repair or maintenance of goods or property, for their operational or structural failure due  
2069 to a defect in materials, workmanship, normal wear and tear, power surge or interruption, or  
2070 accidental damage from handling, with or without additional provision for incidental payment  
2071 of indemnity under limited circumstances, including towing, providing a rental car, providing

2072 emergency road service, and covering food spoilage.

2073 (b) "Service contract" does not include:

2074 (i) mechanical breakdown insurance; or

2075 (ii) a prepaid contract of limited duration that provides for scheduled maintenance

2076 only, regardless of whether the contract is executed before, on, or after May 9, 2017.

2077 (c) "Service contract" includes any contract or agreement to perform or reimburse the  
2078 service contract holder for any one or more of the following services:

2079 (i) the repair or replacement of tires, wheels, or both on a motor vehicle damaged as a  
2080 result of coming into contact with a road hazard;

2081 (ii) the removal of dents, dings, or creases on a motor vehicle that can be repaired using  
2082 the process of paintless dent removal without affecting the existing paint finish and without  
2083 replacing vehicle body panels, sanding, bonding, or painting;

2084 (iii) the repair of chips or cracks in or the replacement of a motor vehicle windshield as  
2085 a result of damage caused by a road hazard, that is primary to the coverage offered by the motor  
2086 vehicle owner's motor vehicle insurance policy; or

2087 (iv) the replacement of a motor vehicle key or key-fob if the key or key-fob becomes  
2088 inoperable, lost, or stolen, except that the replacement of lost or stolen property is limited to  
2089 only the replacement of a lost or stolen motor vehicle key or key-fob.

2090 [~~(5)~~] (6) "Service contract holder" or "contract holder" means a person who purchases a  
2091 service contract.

2092 [~~(6)~~] (7) "Service contract provider" means a person who issues, makes, provides,  
2093 administers, sells or offers to sell a service contract, or who is contractually obligated to  
2094 provide service under a service contract.

2095 [~~(7)~~] (8) "Service contract reimbursement policy" or "reimbursement insurance policy"  
2096 means a policy of insurance providing coverage for all obligations and liabilities incurred by  
2097 the service contract provider or warrantor under the terms of the service contract or vehicle  
2098 protection product warranty issued by the provider or warrantor.

2099 [~~(8)~~] (9) (a) "Vehicle protection product" means a device or system that is:

2100 (i) installed on or applied to a motor vehicle; and

2101 (ii) designed to:

2102 (A) prevent the theft of the vehicle[-]; or

2103 (B) if the vehicle is stolen, aid in the recovery of the vehicle.

2104 (b) "Vehicle protection product" includes:

2105 (i) a vehicle protection product warranty;

2106 (ii) an alarm system;

2107 (iii) a body part marking product;

2108 (iv) a steering lock;

2109 (v) a window etch product;

2110 (vi) a pedal and ignition lock;

2111 (vii) a fuel and ignition kill switch; and

2112 (viii) an electronic, radio, or satellite tracking device.

2113 ~~[(9)]~~ (10) "Vehicle protection product warranty" means a written agreement by a

2114 warrantor that provides that if the vehicle protection product fails to prevent the theft of the

2115 motor vehicle, ~~[that]~~ or aid in the recovery of the motor vehicle within a time period specified

2116 in the warranty, not exceeding 30 days after the day on which the motor vehicle is reported

2117 stolen, the warrantor will reimburse the warranty holder [under the warranty in a fixed amount]

2118 for incidental costs specified in the warranty, not [to exceed \$5,000] exceeding \$5,000, or in a

2119 specified fixed amount not exceeding \$5,000.

2120 ~~[(10)]~~ (11) "Warrantor" means a person who is contractually obligated to the warranty

2121 holder under the terms of a vehicle protection product warranty.

2122 ~~[(11)]~~ (12) "Warranty holder" means the person who purchases a vehicle protection

2123 product, any authorized transferee or assignee of the purchaser, or any other person legally

2124 assuming the purchaser's rights under the vehicle protection product warranty.

2125 Section 13. Section **31A-6a-104** is amended to read:

2126 **31A-6a-104. Required disclosures.**

2127 (1) A ~~[service contract]~~ reimbursement insurance policy insuring a service contract or a

2128 vehicle protection product warranty that is issued, sold, or offered for sale in this state shall

2129 conspicuously state that, upon failure of the service contract provider or warrantor to perform

2130 under the contract, the issuer of the policy shall:

2131 (a) pay on behalf of the service contract provider or warrantor any sums the service

2132 contract provider or warrantor is legally obligated to pay according to the service contract

2133 provider's or warrantor's contractual obligations under the service contract or a vehicle

2134 protection product warranty issued or sold by the service contract provider or warrantor; or

2135 (b) provide the service which the service contract provider is legally obligated to  
2136 perform, according to the service contract provider's contractual obligations under the service  
2137 contract issued or sold by the service contract provider.

2138 (2) (a) A service contract may not be issued, sold, or offered for sale in this state unless  
2139 the service contract contains the following statements in substantially the following form:

2140 (i) "Obligations of the provider under this service contract are guaranteed under a  
2141 service contract reimbursement insurance policy. Should the provider fail to pay or provide  
2142 service on any claim within 60 days after proof of loss has been filed, the contract holder is  
2143 entitled to make a claim directly against the Insurance Company."; [~~and~~]

2144 (ii) "This service contract or warranty is subject to limited regulation by the Utah  
2145 Insurance Department. To file a complaint, contact the Utah Insurance Department."; and

2146 (iii) A service contract or reimbursement insurance policy may not be issued, sold, or  
2147 offered for sale in this state unless the contract contains a statement in substantially the  
2148 following form, "Coverage afforded under this contract is not guaranteed by the Property and  
2149 Casualty Guaranty Association."

2150 (b) A vehicle protection product warranty may not be issued, sold, or offered for sale in  
2151 this state unless the vehicle protection product warranty contains the following statements in  
2152 substantially the following form:

2153 (i) "Obligations of the warrantor under this vehicle protection product warranty are  
2154 guaranteed under a reimbursement insurance policy. Should the warrantor fail to pay on any  
2155 claim within 60 days after proof of loss has been filed, the warranty holder is entitled to make a  
2156 claim directly against the Insurance Company."; [~~and~~]

2157 (ii) "This vehicle protection product warranty is subject to limited regulation by the  
2158 Utah Insurance Department. To file a complaint, contact the Utah Insurance Department."; and

2159 (iii) "The warrantor under this vehicle protection product warranty will reimburse the  
2160 warranty holder as specified in the warranty:

2161 (A) upon the theft of the vehicle; or

2162 (B) if the stolen vehicle is not recovered within a time period specified in the warranty  
2163 following the theft of the vehicle, not to exceed 30 days after the day on which the vehicle is  
2164 reported stolen, at the end of the time period specified in the warranty."

2165 (c) A vehicle protection product warranty, or reimbursement insurance policy, may not  
2166 be issued, sold, or offered for sale in this state unless the warranty contains a statement in  
2167 substantially the following form, "Coverage afforded under this warranty is not guaranteed by  
2168 the Property and Casualty Guaranty Association."

2169 (3) A service contract and a vehicle protection product warranty shall:

2170 (a) conspicuously state the name, address, and a toll free claims service telephone  
2171 number of the reimbursement insurer;

2172 (b) (i) identify the service contract provider, the seller, and the service contract holder;

2173 or

2174 (ii) identify the warrantor, the seller, and the warranty holder;

2175 (c) conspicuously state the total purchase price and the terms under which the service  
2176 contract or warranty is to be paid;

2177 (d) conspicuously state the existence of any deductible amount;

2178 (e) specify the merchandise, service to be provided, and any limitation, exception, or  
2179 exclusion;

2180 (f) state a term, restriction, or condition governing the transferability of the service  
2181 contract or warranty; and

2182 (g) state a term, restriction, or condition that governs cancellation of the service  
2183 contract as provided in Sections [31A-21-303](#) through [31A-21-305](#) by either the contract holder  
2184 or service contract provider.

2185 (4) If prior approval of repair work is required, a service contract shall conspicuously  
2186 state the procedure for obtaining prior approval and for making a claim, including:

2187 (a) a toll free telephone number for claim service; and

2188 (b) a procedure for obtaining reimbursement for emergency repairs performed outside  
2189 of normal business hours.

2190 (5) A preexisting condition clause in a service contract shall specifically state which  
2191 preexisting condition is excluded from coverage.

2192 (6) (a) Except as provided in Subsection (6)(c), a service contract shall state the  
2193 conditions upon which the use of a nonmanufacturers' part is allowed.

2194 (b) A condition described in Subsection (6)(a) shall comply with applicable state and  
2195 federal laws.

2196 (c) This Subsection (6) does not apply to a home warranty contract.

2197 (7) This section applies to a vehicle protection product warranty, except for the  
 2198 requirements of Subsections (3)(d) and (g), (4), (5), and (6). The department may make rules  
 2199 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement  
 2200 the application of this section to a vehicle protection product warranty.

2201 (8) (a) As used in this Subsection (8), "conspicuous statement" means a disclosure that:

2202 (i) appears in all-caps, bold, and 14-point font; and

2203 (ii) provides a space to be initialed by the consumer:

2204 (A) immediately below the printed disclosure; and

2205 (B) before the consumer purchases the vehicle protection product.

2206 ~~[(8)]~~ (b) A vehicle protection product warranty shall contain a conspicuous statement  
 2207 in substantially the following form: "Purchase of this product is optional and is not required in  
 2208 order to finance, lease, or purchase a motor vehicle."

2209 (9) If a vehicle protection product warranty states that the warrantor will reimburse the  
 2210 warranty holder for incidental costs, the vehicle protection product warranty shall state how  
 2211 incidental costs paid under the warranty are calculated.

2212 (10) If a vehicle protection product warranty states that the warrantor will reimburse  
 2213 the warranty holder in a fixed amount, the vehicle protection product warranty shall state the  
 2214 fixed amount.

2215 Section 14. Section **31A-6a-105** is amended to read:

2216 **31A-6a-105. Prohibited acts.**

2217 (1) Except as provided in Subsection **31A-6a-104**(2), a service contract provider or  
 2218 warrantor may not use in [its] the service contract provider or warrantor's name, a contract, or  
 2219 literature:

2220 (a) any of the following words:

2221 (i) "insurance";

2222 (ii) "casualty";

2223 (iii) "surety";

2224 (iv) "mutual"; or

2225 (v) another word descriptive of the insurance, casualty, or surety business; or

2226 (b) a name deceptively similar to the name or description of:

2227 (i) an insurance or surety corporation; or

2228 (ii) another service contract provider.

2229 (2) A service contract provider [~~or the~~], a service contract provider's representative, a  
2230 warrantor, or a warrantor's representative may not:

2231 (a) make, permit, or cause to be made a false or misleading statement in connection  
2232 with the sale, offer to sell, or advertisement of a service contract or vehicle protection product;  
2233 or

2234 (b) deliberately omit a material statement that would be considered misleading if  
2235 omitted, in connection with the sale, offer to sell, or advertisement of a service contract or  
2236 vehicle protection product.

2237 (3) A bank, savings and loan association, insurance company, or other lending  
2238 institution may not require the purchase of a service contract as a condition of a loan.

2239 (4) Except for a bank, savings and loan association, industrial bank, or credit union, a  
2240 service contract provider may not sell, or be the obligated party for:

2241 (a) a guaranteed asset protection waiver, unless registered with the commissioner under  
2242 Chapter 6b, Guaranteed Asset Protection Waiver Act;

2243 (b) a debt cancellation agreement, unless licensed by the commissioner; or

2244 (c) a debt suspension agreement, unless licensed by the commissioner.

2245 (5) A warrantor or [~~its~~] the warrantor's representative may not:

2246 (a) require the purchase of a vehicle protection product as a condition of the financing,  
2247 lease, or purchase of a motor vehicle[-]; or

2248 (b) sell a vehicle protection product to a consumer before providing the consumer, for  
2249 review, a copy of the vehicle protection product warranty that is filed with the Department of  
2250 Insurance.

2251 Section 15. Section **31A-6a-111** is repealed and reenacted to read:

2252 **31A-6a-111. Vehicle protection product warranty requirements.**

2253 (1) A warrantor shall make a reimbursement promised under a vehicle protection  
2254 product warranty as specified in the warranty, regardless of, and not contingent upon, the  
2255 payment of a benefit provided for under the warranty holder's primary vehicle insurance or any  
2256 other contract.

2257 (2) If a vehicle protection product is represented as preventing the theft of a vehicle or

2258 aiding in the recovery of a vehicle, the vehicle protection product warranty shall, at a  
2259 minimum, provide for reimbursement of damage a theft causes to the motor vehicle, if the  
2260 vehicle is recovered within the time period specified in the warranty following the theft of the  
2261 vehicle, not to exceed 30 days after the day on which the vehicle is reported stolen.

2262 Section 16. Section **31A-8-104** is amended to read:

2263 **31A-8-104. Determination of ability to provide services.**

2264 (1) The commissioner may not issue a certificate of authority to an applicant for a  
2265 certificate of authority under this chapter unless the applicant demonstrates to the  
2266 commissioner [~~has determined~~] that the applicant has:

2267 (a) [~~demonstrated~~] the willingness and potential ability to furnish the proposed health  
2268 care services in a manner to assure both availability and accessibility of adequate personnel and  
2269 facilities and continuity of service; and

2270 (b) arrangements for an ongoing quality of health care assurance program concerning  
2271 health care processes and outcomes[~~, established in accordance with rules adopted by the~~  
2272 ~~director of the Department of Health based upon prevailing standards for quality assurance for~~  
2273 ~~other forms of health care delivery in this state; and~~].

2274 [~~(c) a procedure, established in accordance with rules of the director of the Department~~  
2275 ~~of Health, to develop, compile, evaluate, and report statistics relating to the cost of its~~  
2276 ~~operations, the pattern of utilization of its services, the availability and accessibility of its~~  
2277 ~~services, and such other matters as may be reasonably required by the director of the~~  
2278 ~~Department of Health.~~]

2279 [~~(2) Upon receipt of an application for a certificate of authority under this chapter, the~~  
2280 ~~commissioner shall transmit a copy of the application and accompanying documents to the~~  
2281 ~~director of the Department of Health. Upon receipt of the application, the director of the~~  
2282 ~~Department of Health shall review the application, investigate the surrounding facts and~~  
2283 ~~circumstances, and make a finding concerning whether the applicant satisfies the requirements~~  
2284 ~~of Subsection (1). The director of the Department of Health is considered to have found the~~  
2285 ~~applicant to comply with Subsection (1) unless he delivers to the commissioner a finding of~~  
2286 ~~noncompliance within 90 days after receiving the application from the commissioner.~~]

2287 [~~(3) In determining whether the requirements of Subsection (1) are satisfied, the~~  
2288 ~~commissioner shall rely on the findings of the director of the Department of Health delivered to~~

2289 ~~the commissioner in accordance with Subsection (2).]~~

2290 ~~[(4) A finding of noncompliance with Subsection (1) shall specify in what respects the~~  
2291 ~~applicant is deficient in meeting the requirements of Subsection (1).]~~

2292 (2) (a) In accordance with Sections 31A-2-203 and 31A-2-204, the commissioner may  
2293 order an independent audit or examination by one or more technical experts to determine an  
2294 applicant's ability to provide the proposed health care services as described in Subsection (1).

2295 (b) In accordance with Section 31A-2-205, an applicant shall reimburse the  
2296 commissioner for the reasonable cost of an independent audit or examination.

2297 ~~[(5) An organization's certificate of authority issued under this chapter is conclusive~~  
2298 ~~evidence of compliance with Subsection (1), as to the services authorized to be performed~~  
2299 ~~under the certificate of authority, except in a proceeding by the state against the organization.]~~

2300 (3) Licensing under this chapter does not exempt an organization from any licensing  
2301 requirement applicable under Title 26, Chapter 21, Health Care Facility Licensing and  
2302 Inspection Act.

2303 Section 17. Section **31A-8a-102** is amended to read:

2304 **31A-8a-102. Definitions.**

2305 ~~[For purposes of]~~ As used in this chapter:

2306 (1) "Fee" means any periodic charge for use of a discount program.

2307 (2) "Health care provider" means a health care provider as defined in Section

2308 **78B-3-403**, with the exception of "licensed athletic trainer," who:

2309 (a) is practicing within the scope of the provider's license; and

2310 (b) has agreed either directly or indirectly, by contract or any other arrangement with a  
2311 health discount program operator, to provide a discount to enrollees of a health discount  
2312 program.

2313 (3) (a) "Health discount program" means a business arrangement or contract in which a  
2314 person pays fees, dues, charges, or other consideration in exchange for a program that provides  
2315 access to health care providers who agree to provide a discount for health care services.

2316 (b) "Health discount program" does not include a program that does not charge a  
2317 membership fee or require other consideration from the member to use the program's discounts  
2318 for health services.

2319 (4) "Health discount program marketer" means a person, including a private label

2320 entity, that markets, promotes, sells, or distributes a health discount program but does not  
2321 operate a health discount program.

2322 (5) "Health discount program operator" means a person that provides a health discount  
2323 program by entering into a contract or agreement, directly or indirectly, with a person or  
2324 persons in this state who agree to provide discounts for health care services to enrollees of the  
2325 health discount program and determines the charge to members.

2326 (6) "Marketing" means making or causing to be made any communication that contains  
2327 information that relates to a product or contract regulated under this chapter.

2328 ~~[(6)]~~ (7) "Value-added benefit" means a discount offering with no additional charge  
2329 made by a health insurer or health maintenance organization that is licensed under this title, in  
2330 connection with existing contracts with the health insurer or health maintenance organization.

2331 Section 18. Section **31A-15-103** is amended to read:

2332 **31A-15-103. Surplus lines insurance -- Unauthorized insurers.**

2333 (1) Notwithstanding Section **31A-15-102**, ~~[a foreign insurer that has not obtained a~~  
2334 ~~certificate of authority to do business in this state under Section **31A-14-202** may negotiate for~~  
2335 ~~and] when this state is the home state as defined in Section **31A-3-305**, a nonadmitted insurer~~  
2336 may make an insurance contract [with] for coverage of a person in this state and on a risk  
2337 located in this state, subject to the limitations and requirements of this section.

2338 (2) (a) For a contract made under this section, the insurer may, in this state:

2339 (i) inspect the risks to be insured;

2340 (ii) collect premiums;

2341 (iii) adjust losses; and

2342 (iv) do another act reasonably incidental to the contract.

2343 (b) An act described in Subsection (2)(a) may be done through:

2344 (i) an employee; or

2345 (ii) an independent contractor.

2346 (3) (a) Subsections (1) and (2) do not permit a person to solicit business in this state on  
2347 behalf of an insurer that has no certificate of authority.

2348 (b) Insurance placed with a nonadmitted insurer shall be placed ~~[with]~~ by a surplus  
2349 lines producer licensed under Chapter 23a, Insurance Marketing - Licensing Producers,  
2350 Consultants, and Reinsurance Intermediaries.

2351 (c) The commissioner may by rule prescribe how a surplus lines producer may:

2352 (i) pay or permit the payment, commission, or other remuneration on insurance placed  
2353 by the surplus lines producer under authority of the surplus lines producer's license to one  
2354 holding a license to act as an insurance producer; and

2355 (ii) advertise the availability of the surplus lines producer's services in procuring, on  
2356 behalf of a person seeking insurance, a contract with a nonadmitted insurer.

2357 (4) For a contract made under this section, a nonadmitted insurer is subject to Sections  
2358 [31A-23a-402](#), [31A-23a-402.5](#), and [31A-23a-403](#) and the rules adopted under those sections.

2359 (5) A nonadmitted insurer may not issue workers' compensation insurance coverage to  
2360 an employer located in this state, except for stop loss coverage issued to an employer securing  
2361 workers' compensation under Subsection [34A-2-201\(2\)](#).

2362 (6) (a) The commissioner may by rule prohibit making a contract under Subsection (1)  
2363 for a specified class of insurance if authorized insurers provide an established market for the  
2364 class in this state that is adequate and reasonably competitive.

2365 (b) The commissioner may by rule place a restriction or a limitation on and create  
2366 special procedures for making a contract under Subsection (1) for a specified class of insurance  
2367 if:

2368 (i) there have been abuses of placements in the class; or

2369 (ii) the policyholders in the class, because of limited financial resources, business  
2370 experience, or knowledge, cannot protect their own interests adequately.

2371 (c) The commissioner may prohibit an individual insurer from making a contract under  
2372 Subsection (1) and all insurance producers from dealing with the insurer if:

2373 (i) the insurer willfully violates:

2374 (A) this section;

2375 (B) Section [31A-4-102](#), [31A-23a-402](#), [31A-23a-402.5](#), or [31A-26-303](#); or

2376 (C) a rule adopted under a section listed in Subsection (6)(c)(i)(A) or (B);

2377 (ii) the insurer fails to pay the fees and taxes specified under Section [31A-3-301](#); or

2378 (iii) the commissioner has reason to believe that the insurer is:

2379 (A) in an unsound condition;

2380 (B) operated in a fraudulent, dishonest, or incompetent manner; or

2381 (C) in violation of the law of its domicile.

2382 (d) (i) The commissioner may issue one or more lists of [~~unauthorized~~] nonadmitted  
2383 foreign insurers whose:

2384 (A) solidity the commissioner doubts; or

2385 (B) practices the commissioner considers objectionable.

2386 (ii) The commissioner shall issue one or more lists of [~~unauthorized~~] nonadmitted  
2387 foreign insurers the commissioner considers to be reliable and solid.

2388 (iii) In addition to the lists described in Subsections (6)(d)(i) and (ii), the commissioner  
2389 may issue other relevant evaluations of [~~unauthorized~~] nonadmitted insurers.

2390 (iv) An action may not lie against the commissioner or an employee of the department  
2391 for a written or oral communication made in, or in connection with the issuance of, a list or  
2392 evaluation described in this Subsection (6)(d).

2393 (e) A foreign [~~unauthorized~~] nonadmitted insurer shall be listed on the commissioner's  
2394 "reliable" list only if the [~~unauthorized~~] nonadmitted insurer:

2395 (i) delivers a request to the commissioner to be on the list;

2396 (ii) establishes satisfactory evidence of good reputation and financial integrity;

2397 (iii) (A) delivers to the commissioner a copy of the [~~unauthorized~~] nonadmitted  
2398 insurer's current annual statement certified by the insurer[~~;~~ ~~and~~] and, each subsequent year,  
2399 delivers to the commissioner a copy of the nonadmitted insurer's annual statement within 60  
2400 days after the day on which the nonadmitted insurer files the annual statement with the  
2401 insurance regulatory authority where the nonadmitted insurer is domiciled; or

2402 [~~(B) continues each subsequent year to file its annual statements with the~~  
2403 ~~commissioner within 60 days of the day on which it is filed with the insurance regulatory~~  
2404 ~~authority where the insurer is domiciled;]~~

2405 (B) files the nonadmitted insurer's annual statements with the National Association of  
2406 Insurance Commissioners and the nonadmitted insurer's annual statements are available  
2407 electronically from the National Association of Insurance Commissioners;

2408 (iv) (A) [~~(F)~~] is in substantial compliance with the solvency standards in Chapter 17,  
2409 Part 6, Risk-Based Capital, or maintains capital and surplus of at least \$15,000,000, whichever  
2410 is greater; [~~and~~] or

2411 [~~(H) maintains in the United States an irrevocable trust fund in either a national bank or~~  
2412 ~~a member of the Federal Reserve System, or maintains a deposit meeting the statutory deposit~~

2413 requirements for insurers in the state where it is made, which trust fund or deposit:]

2414 [~~(Aa) shall be in an amount not less than \$2,500,000 for the protection of all of the~~  
2415 ~~insurer's policyholders in the United States;~~]

2416 [~~(Bb) may consist of cash, securities, or investments of substantially the same character~~  
2417 ~~and quality as those which are "qualified assets" under Section 31A-17-201; and]~~

2418 [~~(Cc) may include as part of the trust arrangement a letter of credit that qualifies as~~  
2419 ~~acceptable security under Section 31A-17-404.1; or]~~

2420 (B) in the case of any "Lloyd's" or other similar incorporated or unincorporated group  
2421 of alien individual insurers, maintains a trust fund that:

2422 (I) shall be in an amount not less than \$50,000,000 as security to its full amount for all  
2423 policyholders and creditors in the United States of each member of the group;

2424 (II) may consist of cash, securities, or investments of substantially the same character  
2425 and quality as those which are "qualified assets" under Section 31A-17-201; and

2426 (III) may include as part of this trust arrangement a letter of credit that qualifies as  
2427 acceptable security under Section 31A-17-404.1; and

2428 (v) for an alien insurer not domiciled in the United States or a territory of the United  
2429 States, is listed on the Quarterly Listing of Alien Insurers maintained by the National  
2430 Association of Insurance Commissioners International Insurers Department.

2431 (7) (a) Subject to Subsection (7)(b), a surplus lines producer may not, either knowingly  
2432 or without reasonable investigation of the financial condition and general reputation of the  
2433 insurer, place insurance under this section with:

2434 (i) a financially unsound insurer;

2435 (ii) an insurer engaging in unfair practices; or

2436 (iii) an otherwise substandard insurer.

2437 (b) A surplus line producer may place insurance under this section with an insurer  
2438 described in Subsection (7)(a) if the surplus line producer:

2439 (i) gives the applicant notice in writing of the known deficiencies of the insurer or the  
2440 limitations on the surplus line producer's investigation; and

2441 (ii) explains the need to place the business with that insurer.

2442 (c) A copy of the notice described in Subsection (7)(b) shall be kept in the office of the  
2443 surplus line producer for at least five years.

2444 (d) To be financially sound, an insurer shall satisfy standards that are comparable to  
2445 those applied under the laws of this state to an authorized insurer.

2446 (e) An insurer on the "doubtful or objectionable" list under Subsection (6)(d) or an  
2447 insurer not on the commissioner's "reliable" list under Subsection (6)(e) is presumed  
2448 substandard.

2449 (8) (a) A policy issued under this section shall:

2450 (i) include a description of the subject of the insurance; and

2451 (ii) indicate:

2452 (A) the coverage, conditions, and term of the insurance;

2453 (B) the premium charged the policyholder;

2454 (C) the premium taxes to be collected from the policyholder; and

2455 (D) the name and address of the policyholder and insurer.

2456 (b) If the direct risk is assumed by more than one insurer, the policy shall state:

2457 (i) the names and addresses of all insurers; and

2458 (ii) the portion of the entire direct risk each assumes.

2459 (c) A policy issued under this section shall have attached or affixed to the policy the  
2460 following statement: "The insurer issuing this policy does not hold a certificate of authority to  
2461 do business in this state and thus is not fully subject to regulation by the Utah insurance  
2462 commissioner. This policy receives no protection from any of the guaranty associations created  
2463 under Title 31A, Chapter 28, Guaranty Associations."

2464 (9) Upon placing a new or renewal coverage under this section, a surplus lines  
2465 producer shall promptly deliver to the policyholder or the policyholder's agent evidence of the  
2466 insurance consisting either of:

2467 (a) the policy as issued by the insurer; or

2468 (b) if the policy is not available upon placing the coverage, a certificate, cover note, or  
2469 other confirmation of insurance complying with Subsection (8).

2470 (10) If the commissioner finds it necessary to protect the interests of insureds and the  
2471 public in this state, the commissioner may by rule subject a policy issued under this section to  
2472 as much of the regulation provided by this title as is required for a comparable policy written  
2473 by an authorized foreign insurer.

2474 (11) (a) A surplus lines transaction in this state shall be examined to determine whether

2475 it complies with:

2476 (i) the surplus lines tax levied under Chapter 3, Department Funding, Fees, and Taxes;

2477 (ii) the solicitation limitations of Subsection (3);

2478 (iii) the requirement of Subsection (3) that placement be through a surplus lines

2479 producer;

2480 (iv) placement limitations imposed under Subsections (6)(a), (b), and (c); and

2481 (v) the policy form requirements of Subsections (8) and (10).

2482 (b) The examination described in Subsection (11)(a) shall take place as soon as

2483 practicable after the transaction. The surplus lines producer shall submit to the examiner

2484 information necessary to conduct the examination within a period specified by rule.

2485 (c) (i) The examination described in Subsection (11)(a) may be conducted by the

2486 commissioner or by an advisory organization created under Section 31A-15-111 and authorized

2487 by the commissioner to conduct these examinations. The commissioner is not required to

2488 authorize an additional advisory organization to conduct an examination under this Subsection

2489 (11)(c).

2490 (ii) The commissioner's authorization of one or more advisory organizations to act as

2491 examiners under this Subsection (11)(c) shall be:

2492 (A) by rule; and

2493 (B) evidenced by a contract, on a form provided by the commissioner, between the

2494 authorized advisory organization and the department.

2495 (d) (i) (A) A person conducting the examination described in Subsection (11)(a) shall

2496 collect a stamping fee of an amount not to exceed 1% of the policy premium payable in

2497 connection with the transaction.

2498 (B) A stamping fee collected by the commissioner shall be deposited in the General

2499 Fund.

2500 (C) The commissioner shall establish a stamping fee by rule.

2501 (ii) A stamping fee collected by an advisory organization is the property of the advisory

2502 organization to be used in paying the expenses of the advisory organization.

2503 (iii) Liability for paying a stamping fee is as required under Subsection 31A-3-303(1)

2504 for taxes imposed under Section 31A-3-301.

2505 (iv) The commissioner shall adopt a rule dealing with the payment of stamping fees. If

2506 a stamping fee is not paid when due, the commissioner or advisory organization may impose a  
2507 penalty of 25% of the stamping fee due, plus 1-1/2% per month from the time of default until  
2508 full payment of the stamping fee.

2509 ~~[(v) A stamping fee relative to a policy covering a risk located partially in this state~~  
2510 ~~shall be allocated in the same manner as under Subsection 31A-3-303(4).]~~

2511 (e) The commissioner, representatives of the department, advisory organizations,  
2512 representatives and members of advisory organizations, authorized insurers, and surplus lines  
2513 insurers are not liable for damages on account of statements, comments, or recommendations  
2514 made in good faith in connection with their duties under this Subsection (11)(e) or under  
2515 Section 31A-15-111.

2516 (f) An examination conducted under this Subsection (11) and a document or materials  
2517 related to the examination are confidential.

2518 (12) (a) For a surplus lines insurance transaction in the state entered into on or after  
2519 May 13, 2014, if an audit is required by the surplus lines insurance policy, a surplus lines  
2520 insurer:

2521 (i) shall exercise due diligence to initiate an audit of an insured, to determine whether  
2522 additional premium is owed by the insured, by no later than six months after the expiration of  
2523 the term for which premium is paid; and

2524 (ii) may not audit an insured more than three years after the surplus lines insurance  
2525 policy expires.

2526 (b) A surplus lines insurer that does not comply with this Subsection (12) may not  
2527 charge or collect additional premium in excess of the premium agreed to under the surplus  
2528 lines insurance policy.

2529 Section 19. Section 31A-16-103 is amended to read:

2530 **31A-16-103. Acquisition of control of, divestiture of control of, or merger with**  
2531 **domestic insurer.**

2532 (1) (a) A person may not take the actions described in Subsection (1)(b) or (c) unless,  
2533 at the time any offer, request, or invitation is made or any such agreement is entered into, or  
2534 prior to the acquisition of securities if no offer or agreement is involved:

2535 (i) the person files with the commissioner a statement containing the information  
2536 required by this section;

2537 (ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the  
2538 insurer; and

2539 (iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.

2540 (b) Unless the person complies with Subsection (1)(a), a person other than the issuer  
2541 may not make a tender offer for, a request or invitation for tenders of, or enter into any  
2542 agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise,  
2543 any voting security of a domestic insurer if after the acquisition, the person would directly,  
2544 indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.

2545 (c) Unless the person complies with Subsection (1)(a), a person may not enter into an  
2546 agreement to merge with or otherwise to acquire control of:

2547 (i) a domestic insurer; or

2548 (ii) any person controlling a domestic insurer.

2549 (d) For purposes of this section, a controlling person of a domestic insurer seeking to  
2550 divest its controlling interest in the domestic insurer, in any manner, shall file with the  
2551 commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least  
2552 30 days before the cessation of control. The commissioner shall determine those instances in  
2553 which the one or more persons seeking to divest or to acquire a controlling interest in an  
2554 insurer, will be required to file for and obtain approval of the transaction. The information  
2555 shall remain confidential until the conclusion of the transaction unless the commissioner, in the  
2556 commissioner's discretion, determines that confidential treatment will interfere with  
2557 enforcement of this section. If the statement referred to in Subsection (1)(a) is otherwise filed,  
2558 this Subsection (1)(d) does not apply.

2559 (e) With respect to a transaction subject to this section, the acquiring person shall also  
2560 file a pre-acquisition notification with the commissioner, which shall contain the information  
2561 set forth in Section [31A-16-104.5](#). A failure to file the notification may be subject to penalties  
2562 specified in Section [31A-16-104.5](#).

2563 (f) (i) For purposes of this section, a domestic insurer includes any person controlling a  
2564 domestic insurer unless the person as determined by the commissioner is either directly or  
2565 through its affiliates primarily engaged in business other than the business of insurance.

2566 (ii) The controlling person described in Subsection (1)(f)(i) shall file with the  
2567 commissioner a preacquisition notification containing the information required in Subsection

2568 (2) 30 calendar days before the proposed effective date of the acquisition.  
2569 (iii) For the purposes of this section, "person" does not include any securities broker  
2570 that in the usual and customary brokers function holds less than 20% of:  
2571 (A) the voting securities of an insurance company; or  
2572 (B) any person that controls an insurance company.  
2573 (iv) This section applies to all domestic insurers and other entities licensed under:  
2574 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;  
2575 (B) Chapter 7, Nonprofit Health Service Insurance Corporations;  
2576 (C) Chapter 8, Health Maintenance Organizations and Limited Health Plans;  
2577 (D) Chapter 9, Insurance Fraternal; and  
2578 (E) Chapter 11, Motor Clubs.  
2579 (g) (i) An agreement for acquisition of control or merger as contemplated by this  
2580 Subsection (1) is not valid or enforceable unless the agreement:  
2581 (A) is in writing; and  
2582 (B) includes a provision that the agreement is subject to the approval of the  
2583 commissioner upon the filing of any applicable statement required under this chapter.  
2584 (ii) A written agreement for acquisition or control that includes the provision described  
2585 in Subsection (1)(g)(i) satisfies the requirements of this Subsection (1).  
2586 (2) The statement to be filed with the commissioner under Subsection (1) shall be  
2587 made under oath or affirmation and shall contain the following information:  
2588 (a) the name and address of the "acquiring party," which means each person by whom  
2589 or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to  
2590 be effected; and  
2591 (i) if the person is an individual:  
2592 (A) the person's principal occupation;  
2593 (B) a listing of all offices and positions held by the person during the past five years;  
2594 and  
2595 (C) any conviction of crimes other than minor traffic violations during the past 10  
2596 years; and  
2597 (ii) if the person is not an individual:  
2598 (A) a report of the nature of its business operations during:

- 2599 (I) the past five years; or
- 2600 (II) for any lesser period as the person and any of its predecessors has been in
- 2601 existence;
- 2602 (B) an informative description of the business intended to be done by the person and
- 2603 the person's subsidiaries;
- 2604 (C) a list of all individuals who are or who have been selected to become directors or
- 2605 executive officers of the person, or individuals who perform, or who will perform functions
- 2606 appropriate to such positions; and
- 2607 (D) for each individual described in Subsection (2)(a)(ii)(C), the information required
- 2608 by Subsection (2)(a)(i) for each individual;
- 2609 (b) (i) the source, nature, and amount of the consideration used or to be used in
- 2610 effecting the merger or acquisition of control;
- 2611 (ii) a description of any transaction in which funds were or are to be obtained for the
- 2612 purpose of effecting the merger or acquisition of control, including any pledge of:
- 2613 (A) the insurer's stock; or
- 2614 (B) the stock of any of the insurer's subsidiaries or controlling affiliates; and
- 2615 (iii) the identity of persons furnishing the consideration;
- 2616 (c) (i) fully audited financial information, or other financial information considered
- 2617 acceptable by the commissioner, of the earnings and financial condition of each acquiring party
- 2618 for:
- 2619 (A) the preceding five fiscal years of each acquiring party; or
- 2620 (B) any lesser period the acquiring party and any of its predecessors shall have been in
- 2621 existence; and
- 2622 (ii) unaudited information:
- 2623 (A) similar to the information described in Subsection (2)(c)(i); and
- 2624 (B) prepared within the 90 days prior to the filing of the statement;
- 2625 (d) any plans or proposals which each acquiring party may have to:
- 2626 (i) liquidate the insurer;
- 2627 (ii) sell its assets;
- 2628 (iii) merge or consolidate the insurer with any person; or
- 2629 (iv) make any other material change in the insurer's:

- 2630 (A) business;
- 2631 (B) corporate structure; or
- 2632 (C) management;
- 2633 (e) (i) the number of shares of any security referred to in Subsection (1) that each
- 2634 acquiring party proposes to acquire;
- 2635 (ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in
- 2636 Subsection (1); and
- 2637 (iii) a statement as to the method by which the fairness of the proposal was arrived at;
- 2638 (f) the amount of each class of any security referred to in Subsection (1) that:
- 2639 (i) is beneficially owned; or
- 2640 (ii) concerning which there is a right to acquire beneficial ownership by each acquiring
- 2641 party;
- 2642 (g) a full description of any contract, arrangement, or understanding with respect to any
- 2643 security referred to in Subsection (1) in which any acquiring party is involved, including:
- 2644 (i) the transfer of any of the securities;
- 2645 (ii) joint ventures;
- 2646 (iii) loan or option arrangements;
- 2647 (iv) puts or calls;
- 2648 (v) guarantees of loans;
- 2649 (vi) guarantees against loss or guarantees of profits;
- 2650 (vii) division of losses or profits; or
- 2651 (viii) the giving or withholding of proxies;
- 2652 (h) a description of the purchase by any acquiring party of any security referred to in
- 2653 Subsection (1) during the 12 calendar months preceding the filing of the statement including:
- 2654 (i) the dates of purchase;
- 2655 (ii) the names of the purchasers; and
- 2656 (iii) the consideration paid or agreed to be paid for the purchase;
- 2657 (i) a description of:
- 2658 (i) any recommendations to purchase by any acquiring party any security referred to in
- 2659 Subsection (1) made during the 12 calendar months preceding the filing of the statement; or
- 2660 (ii) any recommendations made by anyone based upon interviews or at the suggestion

2661 of the acquiring party;

2662 (j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange  
2663 offers for, and agreements to acquire or exchange any securities referred to in Subsection (1);  
2664 and

2665 (ii) if distributed, copies of additional soliciting material relating to the transactions  
2666 described in Subsection (2)(j)(i);

2667 (k) (i) the term of any agreement, contract, or understanding made with, or proposed to  
2668 be made with, any broker-dealer as to solicitation of securities referred to in Subsection (1) for  
2669 tender; and

2670 (ii) the amount of any fees, commissions, or other compensation to be paid to  
2671 broker-dealers with regard to any agreement, contract, or understanding described in  
2672 Subsection (2)(k)(i);

2673 (l) an agreement by the person required to file the statement referred to in Subsection  
2674 (1) that it will provide the annual report, specified in Section 31A-16-105, for so long as  
2675 control exists;

2676 (m) an acknowledgment by the person required to file the statement referred to in  
2677 Subsection (1) that the person and all subsidiaries within its control in the insurance holding  
2678 company system will provide information to the commissioner upon request as necessary to  
2679 evaluate enterprise risk to the insurer; and

2680 (n) any additional information the commissioner requires by rule, which the  
2681 commissioner determines to be:

2682 (i) necessary or appropriate for the protection of policyholders of the insurer; or

2683 (ii) in the public interest.

2684 (3) The department may request:

2685 (a) (i) criminal background information maintained pursuant to Title 53, Chapter 10,  
2686 Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

2687 (ii) complete Federal Bureau of Investigation criminal background checks through the  
2688 national criminal history system.

2689 (b) Information obtained by the department from the review of criminal history records  
2690 received under Subsection (3)(a) shall be used by the department for the purpose of:

2691 (i) verifying the information in Subsection (2)(a)(i);

2692 (ii) determining the integrity of persons who would control the operation of an insurer;  
2693 and

2694 (iii) preventing persons who violate 18 U.S.C. Sec. 1033 from engaging in the business  
2695 of insurance in the state.

2696 (c) If the department requests the criminal background information, the department  
2697 shall:

2698 (i) pay to the Department of Public Safety the costs incurred by the Department of  
2699 Public Safety in providing the department criminal background information under Subsection  
2700 (3)(a)(i);

2701 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau  
2702 of Investigation in providing the department criminal background information under  
2703 Subsection (3)(a)(ii); and

2704 (iii) charge the person required to file the statement referred to in Subsection (1) a fee  
2705 equal to the aggregate of Subsections (3)(c)(i) and (ii).

2706 (4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in  
2707 the lender's ordinary course of business, the identity of the lender shall remain confidential, if  
2708 the person filing the statement so requests.

2709 (b) (i) Under Subsection (2)(e), the commissioner may require a statement of the  
2710 adjusted book value assigned by the acquiring party to each security in arriving at the terms of  
2711 the offer.

2712 (ii) For purposes of this Subsection (4)(b), "adjusted book value" means each security's  
2713 proportional interest in the capital and surplus of the insurer with adjustments that reflect:

2714 (A) market conditions;

2715 (B) business in force; and

2716 (C) other intangible assets or liabilities of the insurer.

2717 (c) The description required by Subsection (2)(g) shall identify the persons with whom  
2718 the contracts, arrangements, or understandings have been entered into.

2719 (5) (a) If the person required to file the statement referred to in Subsection (1) is a  
2720 partnership, limited partnership, syndicate, or other group, the commissioner may require that  
2721 all the information called for by Subsection (2), (3), or (4) shall be given with respect to each:

2722 (i) partner of the partnership or limited partnership;

2723 (ii) member of the syndicate or group; and

2724 (iii) person who controls the partner or member.

2725 (b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation,  
2726 or if the person required to file the statement referred to in Subsection (1) is a corporation, the  
2727 commissioner may require that the information called for by Subsection (2) shall be given with  
2728 respect to:

2729 (i) the corporation;

2730 (ii) each officer and director of the corporation; and

2731 (iii) each person who is directly or indirectly the beneficial owner of more than 10% of  
2732 the outstanding voting securities of the corporation.

2733 (6) If any material change occurs in the facts set forth in the statement filed with the  
2734 commissioner and sent to the insurer pursuant to Subsection (2), an amendment setting forth  
2735 the change, together with copies of all documents and other material relevant to the change,  
2736 shall be filed with the commissioner and sent to the insurer within two business days after the  
2737 filing person learns of such change.

2738 (7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection  
2739 (1) is proposed to be made by means of a registration statement under the Securities Act of  
2740 1933, or under circumstances requiring the disclosure of similar information under the  
2741 Securities Exchange Act of 1934, or under a state law requiring similar registration or  
2742 disclosure, a person required to file the statement referred to in Subsection (1) may use copies  
2743 of any registration or disclosure documents in furnishing the information called for by the  
2744 statement.

2745 (8) (a) The commissioner shall approve any merger or other acquisition of control  
2746 referred to in Subsection (1), unless~~[-after a public hearing on the merger or acquisition,]~~ the  
2747 commissioner finds that:

2748 (i) after the change of control, the domestic insurer referred to in Subsection (1) would  
2749 not be able to satisfy the requirements for the issuance of a license to write the line or lines of  
2750 insurance for which it is presently licensed;

2751 (ii) the effect of the merger or other acquisition of control would:

2752 (A) substantially lessen competition in insurance in this state; or

2753 (B) tend to create a monopoly in insurance;

- 2754 (iii) the financial condition of any acquiring party might:
- 2755 (A) jeopardize the financial stability of the insurer; or
- 2756 (B) prejudice the interest of:
- 2757 (I) its policyholders; or
- 2758 (II) any remaining securityholders who are unaffiliated with the acquiring party;
- 2759 (iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in
- 2760 Subsection (1) are unfair and unreasonable to the securityholders of the insurer;
- 2761 (v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its
- 2762 assets, or consolidate or merge it with any person, or to make any other material change in its
- 2763 business or corporate structure or management, are:
- 2764 (A) unfair and unreasonable to policyholders of the insurer; and
- 2765 (B) not in the public interest; or
- 2766 (vi) the competence, experience, and integrity of those persons who would control the
- 2767 operation of the insurer are such that it would not be in the interest of the policyholders of the
- 2768 insurer and the public to permit the merger or other acquisition of control.
- 2769 (b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not
- 2770 be considered unfair if the adjusted book values under Subsection (2)(e):
- 2771 (i) are disclosed to the securityholders; and
- 2772 (ii) determined by the commissioner to be reasonable.
- 2773 (9) For a merger or other acquisition of control described in Subsection (1), the
- 2774 commissioner:
- 2775 (a) may hold a public hearing on the merger or other acquisition at the commissioner's
- 2776 discretion; and
- 2777 (b) shall hold a public hearing on the merger or other acquisition upon request by the
- 2778 acquiring party, the insurer, or any other interested party.
- 2779 ~~[(9)]~~ (10) (a) The commissioner shall hold a public hearing ~~[referred to in Subsection~~
- 2780 ~~(8) shall be held within 30]~~ under Subsection (9) no later than 45 days after the day on which
- 2781 the statement required by Subsection (1) is filed.
- 2782 (b) (i) ~~[At]~~ The commissioner shall give at least 20 days notice of the hearing ~~[shall be~~
- 2783 ~~given by the commissioner]~~ to the person filing the statement.
- 2784 (ii) Affected parties may waive the notice required by this Subsection (9)(b).

2785 (iii) Not less than seven days notice of the public hearing shall be given by the person  
2786 filing the statement to:

2787 (A) the insurer; and

2788 (B) any person designated by the commissioner.

2789 (c) The commissioner shall make a determination within 30 days after the conclusion  
2790 of the hearing.

2791 (d) At the hearing, the person filing the statement, the insurer, any person to whom  
2792 notice of hearing was sent, and any other person whose interest may be affected by the hearing  
2793 may:

2794 (i) present evidence;

2795 (ii) examine and cross-examine witnesses; and

2796 (iii) offer oral and written arguments.

2797 (e) (i) A person or insurer described in Subsection [~~(9)~~] (10)(d) may conduct discovery  
2798 proceedings in the same manner as is presently allowed in the district courts of this state.

2799 (ii) All discovery proceedings shall be concluded not later than three days before the  
2800 commencement of the public hearing.

2801 [~~(10)~~] (11) If the proposed acquisition of control will require the approval of more than  
2802 one commissioner, the public hearing [~~referred to~~] described in Subsection (9)[~~(a)~~] may be held  
2803 on a consolidated basis upon request of the person filing the statement referred to in Subsection  
2804 (1). The person shall file the statement referred to in Subsection (1) with the National  
2805 Association of Insurance Commissioners within five days of making the request for a public  
2806 hearing. A commissioner may opt out of a consolidated hearing and shall provide notice to the  
2807 applicant of the opt-out within 10 days of the receipt of the statement referred to in Subsection  
2808 (1). A hearing conducted on a consolidated basis shall be public and shall be held within the  
2809 United States before the commissioners of the states in which the insurers are domiciled. The  
2810 commissioners shall hear and receive evidence. A commissioner may attend a hearing under  
2811 this Subsection [~~(10)~~] (11) in person or by telecommunication.

2812 [~~(11)~~] (12) In connection with a change of control of a domestic insurer, any  
2813 determination by the commissioner that the person acquiring control of the insurer shall be  
2814 required to maintain or restore the capital of the insurer to the level required by the laws and  
2815 regulations of this state shall be made not later than 60 days after the date of notification of the

2816 change in control submitted pursuant to Subsection (1).

2817           ~~[(12)]~~ (13) (a) The commissioner may retain technical experts to assist in reviewing all,  
2818 or a portion of, information filed in connection with a proposed merger or other acquisition of  
2819 control referred to in Subsection (1).

2820           (b) In determining whether any of the conditions in Subsection (8) exist, the  
2821 commissioner may consider the findings of technical experts employed to review applicable  
2822 filings.

2823           (c) (i) A technical expert employed under Subsection ~~[(12)]~~ (13)(a) shall present to the  
2824 commissioner a statement of all expenses incurred by the technical expert in conjunction with  
2825 the technical expert's review of a proposed merger or other acquisition of control.

2826           (ii) At the commissioner's direction the acquiring person shall compensate the technical  
2827 expert at customary rates for time and expenses:

2828           (A) necessarily incurred; and

2829           (B) approved by the commissioner.

2830           (iii) The acquiring person shall:

2831           (A) certify the consolidated account of all charges and expenses incurred for the review  
2832 by technical experts;

2833           (B) retain a copy of the consolidated account described in Subsection ~~[(12)]~~  
2834 ~~(13)~~(c)(iii)(A); and

2835           (C) file with the department as a public record a copy of the consolidated account  
2836 described in Subsection ~~[(12)]~~ (13)(c)(iii)(A).

2837           ~~[(13)]~~ (14) (a) (i) If a domestic insurer proposes to merge into another insurer, any  
2838 securityholder electing to exercise a right of dissent may file with the insurer a written request  
2839 for payment of the adjusted book value given in the statement required by Subsection (1) and  
2840 approved under Subsection (8), in return for the surrender of the security holder's securities.

2841           (ii) The request described in Subsection ~~[(13)]~~ (14)(a)(i) shall be filed not later than 10  
2842 days after the day of the securityholders' meeting where the corporate action is approved.

2843           (b) The dissenting securityholder is entitled to and the insurer is required to pay to the  
2844 dissenting securityholder the specified value within 60 days of receipt of the dissenting security  
2845 holder's security.

2846           (c) Persons electing under this Subsection ~~[(13)]~~ (14) to receive cash for their securities

2847 waive the dissenting shareholder and appraisal rights otherwise applicable under Title 16,  
2848 Chapter 10a, Part 13, Dissenters' Rights.

2849 (d) (i) This Subsection [~~(13)~~] (14) provides an elective procedure for dissenting  
2850 securityholders to resolve their objections to the plan of merger.

2851 (ii) This section does not restrict the rights of dissenting securityholders under Title 16,  
2852 Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this  
2853 Subsection [~~(13)~~] (14).

2854 [~~(14)~~] (15) (a) All statements, amendments, or other material filed under Subsection  
2855 (1), and all notices of public hearings held under Subsection (8), shall be mailed by the insurer  
2856 to its securityholders within five business days after the insurer has received the statements,  
2857 amendments, other material, or notices.

2858 (b) (i) Mailing expenses shall be paid by the person making the filing.

2859 (ii) As security for the payment of mailing expenses, that person shall file with the  
2860 commissioner an acceptable bond or other deposit in an amount determined by the  
2861 commissioner.

2862 [~~(15)~~] (16) This section does not apply to any offer, request, invitation, agreement, or  
2863 acquisition that the commissioner by order exempts from the requirements of this section as:

2864 (a) not having been made or entered into for the purpose of, and not having the effect  
2865 of, changing or influencing the control of a domestic insurer; or

2866 (b) otherwise not comprehended within the purposes of this section.

2867 [~~(16)~~] (17) The following are violations of this section:

2868 (a) the failure to file any statement, amendment, or other material required to be filed  
2869 pursuant to Subsections (1), (2), and (5); or

2870 (b) the effectuation, or any attempt to effectuate, an acquisition of control of,  
2871 divestiture of, or merger with a domestic insurer unless the commissioner has given the  
2872 commissioner's approval to the acquisition or merger.

2873 [~~(17)~~] (18) (a) The courts of this state are vested with jurisdiction over:

2874 (i) a person who:

2875 (A) files a statement with the commissioner under this section; and

2876 (B) is not resident, domiciled, or authorized to do business in this state; and

2877 (ii) overall actions involving persons described in Subsection [~~(17)~~] (18)(a)(i) arising

2878 out of a violation of this section.

2879 (b) A person described in Subsection [~~(17)~~] (18)(a) is considered to have performed  
2880 acts equivalent to and constituting an appointment of the commissioner by that person, to be  
2881 that person's lawful agent upon whom may be served all lawful process in any action, suit, or  
2882 proceeding arising out of a violation of this section.

2883 (c) A copy of a lawful process described in Subsection [~~(17)~~] (18)(b) shall be:

2884 (i) served on the commissioner; and

2885 (ii) transmitted by registered or certified mail by the commissioner to the person at that  
2886 person's last-known address.

2887 Section 20. Section 31A-22-612 is amended to read:

2888 **31A-22-612. Conversion privileges for insured former spouse.**

2889 (1) An accident and health insurance policy, which in addition to covering the insured  
2890 also provides coverage to the spouse of the insured, may not contain a provision for  
2891 termination of coverage of a spouse covered under the policy, except by entry of a valid decree  
2892 of divorce, legal separation, or annulment between the parties.

2893 (2) Every policy which contains this type of provision shall provide that upon the entry  
2894 of the divorce decree the spouse is entitled to have issued an individual policy of accident and  
2895 health insurance without evidence of insurability, upon application to the company and  
2896 payment of the appropriate premium. The policy shall provide the coverage being issued  
2897 which is most nearly similar to the terminated coverage. Probationary or waiting periods in the  
2898 policy are considered satisfied to the extent the coverage was in force under the prior policy.

2899 (3) When the insurer receives actual notice that the coverage of a spouse is to be  
2900 terminated because of a divorce, legal separation, or annulment, the insurer shall promptly  
2901 provide the spouse written notification of the right to obtain individual coverage as provided in  
2902 Subsection (2), the premium amounts required, and the manner, place, and time in which  
2903 premiums may be paid. The premium is determined in accordance with the insurer's table of  
2904 premium rates applicable to the age and class of risk of the persons to be covered and to the  
2905 type and amount of coverage provided. If the spouse applies and tenders the first monthly  
2906 premium to the insurer within 30 days after receiving the notice provided by this Subsection  
2907 (3), the spouse shall receive individual coverage that commences immediately upon  
2908 termination of coverage under the insured's policy.

2909 (4) This section does not apply to accident and health insurance policies offered on a  
2910 group blanket basis or a health benefit plan.

2911 Section 21. Section **31A-22-618.6** is amended to read:

2912 **31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit**  
2913 **plans.**

2914 (1) Except as otherwise provided in this section, a group health benefit plan for a plan  
2915 sponsor is renewable and continues in force:

2916 (a) with respect to all eligible employees and dependents; and

2917 (b) at the option of the plan sponsor.

2918 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

2919 (a) for noncompliance with the insurer's employer contribution requirements;

2920 (b) if there is no longer any enrollee under the group health plan who lives, resides, or  
2921 works in:

2922 (i) the service area of the insurer; or

2923 (ii) the area for which the insurer is authorized to do business;

2924 (c) for coverage made available in the small or large employer market only through an  
2925 association, if:

2926 (i) the employer's membership in the association ceases; and

2927 (ii) the coverage is terminated uniformly without regard to any health status-related  
2928 factor relating to any covered individual; or

2929 (d) for noncompliance with the insurer's minimum employee participation  
2930 requirements, except as provided in Subsection (3).

2931 (3) If a small employer [~~employs fewer than two eligible employees~~] no longer  
2932 employs at least one eligible employee, a carrier may not discontinue or not renew the health  
2933 benefit plan until the first renewal date following the beginning of a new plan year, even if the  
2934 carrier knows at the beginning of the plan year that the employer no longer has at least [~~two~~  
2935 ~~current employees~~] one eligible employee.

2936 (4) (a) A small employer that, after purchasing a health benefit plan in the small group  
2937 market, employs on average more than 50 eligible employees on each business day in a  
2938 calendar year may continue to renew the health benefit plan purchased in the small group  
2939 market.

2940 (b) A large employer that, after purchasing a health benefit plan in the large group  
2941 market, employs on average fewer than 51 eligible employees on each business day in a  
2942 calendar year may continue to renew the health benefit plan purchased in the large group  
2943 market.

2944 (5) A health benefit plan for a plan sponsor may be discontinued if:

2945 (a) a condition described in Subsection (2) exists;

2946 (b) the plan sponsor fails to pay premiums or contributions in accordance with the  
2947 terms of the contract;

2948 (c) the plan sponsor:

2949 (i) performs an act or practice that constitutes fraud; or

2950 (ii) makes an intentional misrepresentation of material fact under the terms of the  
2951 coverage;

2952 (d) the insurer:

2953 (i) elects to discontinue offering a particular health benefit plan product delivered or  
2954 issued for delivery in this state; and

2955 (ii) (A) provides notice of the discontinuation in writing to each plan sponsor,  
2956 employee, or dependent of a plan sponsor or an employee, at least 90 days before the date the  
2957 coverage will be discontinued;

2958 (B) provides notice of the discontinuation in writing to the commissioner, and at least  
2959 three working days before the date the notice is sent to the affected plan sponsors, employees,  
2960 and dependents of the plan sponsors or employees;

2961 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all  
2962 other health benefit plans currently being offered by the insurer in the market or, in the case of  
2963 a large employer, any other health benefit plans currently being offered in that market; and

2964 (D) in exercising the option to discontinue that health benefit plan and in offering the  
2965 option of coverage in this section, acts uniformly without regard to the claims experience of a  
2966 plan sponsor, any health status-related factor relating to any covered participant or beneficiary,  
2967 or any health status-related factor relating to any new participant or beneficiary who may  
2968 become eligible for the coverage; or

2969 (e) the insurer:

2970 (i) elects to discontinue all of the insurer's health benefit plans in:

- 2971 (A) the small employer market;
- 2972 (B) the large employer market; or
- 2973 (C) both the small employer and large employer markets; and
- 2974 (ii) (A) provides notice of the discontinuation in writing to each plan sponsor,
- 2975 employee, or dependent of a plan sponsor or an employee at least 180 days before the date the
- 2976 coverage will be discontinued;
- 2977 (B) provides notice of the discontinuation in writing to the commissioner in each state
- 2978 in which an affected insured individual is known to reside and, at least 30 working days before
- 2979 the date the notice is sent to the affected plan sponsors, employees, and the dependents of the
- 2980 plan sponsors or employees;
- 2981 (C) discontinues and nonrenews all plans issued or delivered for issuance in the market
- 2982 described in Subsection (5)(e)(i); and
- 2983 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
- 2984 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
- 2985 discontinued if after issuance of coverage the eligible employee:
- 2986 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
- 2987 or
- 2988 (ii) makes an intentional misrepresentation of material fact in connection with the
- 2989 coverage.
- 2990 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
- 2991 (i) 12 months after the date of discontinuance; and
- 2992 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
- 2993 to reenroll.
- 2994 (c) At the time the eligible employee's coverage is discontinued under Subsection
- 2995 (6)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
- 2996 discontinued.
- 2997 (d) An eligible employee may not be discontinued under this Subsection (6) because of
- 2998 a fraud or misrepresentation that relates to health status.
- 2999 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
- 3000 the employer:
- 3001 (a) with respect to coverage provided to an employer member of the association; and

- 3002 (b) if the health benefit plan is made available by an insurer in the employer market
- 3003 only through:
- 3004 (i) an association;
- 3005 (ii) a trust; or
- 3006 (iii) a discretionary group.

- 3007 (8) An insurer may modify a health benefit plan for a plan sponsor only:
- 3008 (a) at the time of coverage renewal; and
- 3009 (b) if the modification is effective uniformly among all plans with that product.

3010 Section 22. Section **31A-22-629** is amended to read:

3011 **31A-22-629. Adverse benefit determination review process.**

3012 (1) As used in this section:

3013 (a) (i) "Adverse benefit determination" means the:

3014 (A) denial of a benefit;

3015 (B) reduction of a benefit;

3016 (C) termination of a benefit; or

3017 (D) failure to provide or make payment, in whole or in part, for a benefit.

3018 (ii) "Adverse benefit determination" includes:

3019 (A) denial, reduction, termination, or failure to provide or make payment that is based  
3020 on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

3021 (B) denial, reduction, or termination of, or a failure to provide or make payment, in  
3022 whole or in part, for, a benefit resulting from the application of a utilization review; or

3023 (C) failure to cover an item or service for which benefits are otherwise provided  
3024 because it is determined to be:

3025 (I) experimental;

3026 (II) investigational; or

3027 (III) not medically necessary or appropriate.

3028 (b) "Independent review" means a process that:

3029 (i) is a voluntary option for the resolution of an adverse benefit determination;

3030 (ii) is conducted at the discretion of the claimant;

3031 (iii) is conducted by an independent review organization designated by the [insurer]  
3032 commissioner;

3033 (iv) renders an independent and impartial decision on an adverse benefit determination  
3034 submitted by an insured; and

3035 (v) may not require the insured to pay a fee for requesting the independent review.

3036 (c) "Independent review organization" means a person, subject to Subsection (6), who  
3037 conducts an independent external review of adverse determinations.

3038 (d) "Insured" is as defined in Section 31A-1-301 and includes a person who is  
3039 authorized to act on the insured's behalf.

3040 (e) "Insurer" is as defined in Section 31A-1-301 and includes:

3041 (i) a health maintenance organization; and

3042 (ii) a third party administrator that offers, sells, manages, or administers a health  
3043 insurance policy or health maintenance organization contract that is subject to this title.

3044 (f) "Internal review" means the process an insurer uses to review an insured's adverse  
3045 benefit determination before the adverse benefit determination is submitted for independent  
3046 review.

3047 (2) This section applies generally to health insurance policies, health maintenance  
3048 organization contracts, and income replacement or disability income policies.

3049 (3) (a) An insured may submit an adverse benefit determination to the insurer.

3050 (b) The insurer shall conduct an internal review of the insured's adverse benefit  
3051 determination.

3052 (c) An insured who disagrees with the results of an internal review may submit the  
3053 adverse benefit determination for an independent review if the adverse benefit determination  
3054 involves:

3055 (i) payment of a claim regarding medical necessity; or

3056 (ii) denial of a claim regarding medical necessity.

3057 (4) The commissioner shall adopt rules that establish minimum standards for:

3058 (a) internal reviews;

3059 (b) independent reviews to ensure independence and impartiality;

3060 (c) the types of adverse benefit determinations that may be submitted to an independent  
3061 review; and

3062 (d) the timing of the review process, including an expedited review when medically  
3063 necessary.

- 3064 (5) Nothing in this section may be construed as:
- 3065 (a) expanding, extending, or modifying the terms of a policy or contract with respect to
- 3066 benefits or coverage;
- 3067 (b) permitting an insurer to charge an insured for the internal review of an adverse
- 3068 benefit determination;
- 3069 (c) restricting the use of arbitration in connection with or subsequent to an independent
- 3070 review; or
- 3071 (d) altering the legal rights of any party to seek court or other redress in connection
- 3072 with:
- 3073 (i) an adverse decision resulting from an independent review, except that if the insurer
- 3074 is the party seeking legal redress, the insurer shall pay for the reasonable attorney fees of the
- 3075 insured related to the action and court costs; or
- 3076 (ii) an adverse benefit determination or other claim that is not eligible for submission
- 3077 to independent review.
- 3078 (6) (a) An independent review organization in relation to the insurer may not be:
- 3079 (i) the insurer;
- 3080 (ii) the health plan;
- 3081 (iii) the health plan's fiduciary;
- 3082 (iv) the employer; or
- 3083 (v) an employee or agent of any one listed in Subsections (6)(a)(i) through (iv).
- 3084 (b) An independent review organization may not have a material professional, familial,
- 3085 or financial conflict of interest with:
- 3086 (i) the health plan;
- 3087 (ii) an officer, director, or management employee of the health plan;
- 3088 (iii) the enrollee;
- 3089 (iv) the enrollee's health care provider;
- 3090 (v) the health care provider's medical group or independent practice association;
- 3091 (vi) a health care facility where service would be provided; or
- 3092 (vii) the developer or manufacturer of the service that would be provided.

3093 Section 23. Section **31A-22-701** is amended to read:

3094 **31A-22-701. Groups eligible for group or blanket insurance.**

3095 (1) As used in this section, "association group" means a lawfully formed association of  
3096 individuals or business entities that:

3097 (a) purchases insurance on a group basis on behalf of members; and

3098 (b) is formed and maintained in good faith for purposes other than obtaining insurance.

3099 (2) A group accident and health insurance policy may be issued to:

3100 (a) a group:

3101 (i) to which a group life insurance policy may be issued under [~~Sections~~] Section  
3102 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-506, or 31A-22-507 [~~, and 31A-22-509~~]; and

3103 (ii) that is formed and maintained in good faith for a purpose other than obtaining  
3104 insurance;

3105 (b) an association group authorized by the commissioner that:

3106 (i) has been actively in existence for at least five years;

3107 (ii) has a constitution and bylaws;

3108 (iii) has a shared or common purpose that is not primarily a business or customer  
3109 relationship;

3110 (iv) is formed and maintained in good faith for purposes other than obtaining  
3111 insurance;

3112 (v) does not condition membership in the association group on any health status-related  
3113 factor relating to an individual, including an employee of an employer or a dependent of an  
3114 employee;

3115 (vi) makes accident and health insurance coverage offered through the association  
3116 group available to all members regardless of any health status-related factor relating to the  
3117 members or individuals eligible for coverage through a member;

3118 (vii) does not make accident and health insurance coverage offered through the  
3119 association group available other than in connection with a member of the association group;  
3120 and

3121 (viii) is actuarially sound; or

3122 (c) a group specifically authorized by the commissioner [~~under Section 31A-22-509~~],  
3123 upon a finding that:

3124 (i) authorization is not contrary to the public interest;

3125 (ii) the group is actuarially sound;

3126 (iii) formation of the proposed group may result in economies of scale in acquisition,  
3127 administrative, marketing, and brokerage costs;

3128 (iv) the insurance policy, insurance certificate, or other indicia of coverage that will be  
3129 offered to the proposed group is substantially equivalent to insurance policies that are  
3130 otherwise available to similar groups;

3131 (v) the group would not present hazards of adverse selection;

3132 (vi) the premiums for the insurance policy and any contributions by or on behalf of the  
3133 insured persons are reasonable in relation to the benefits provided; and

3134 (vii) the group is formed and maintained in good faith for a purpose other than  
3135 obtaining insurance.

3136 (3) A blanket accident and health insurance policy:

3137 (a) covers a defined class of persons;

3138 (b) may not be offered or underwritten on an individual basis;

3139 (c) shall cover only a group that is:

3140 (i) actuarially sound; and

3141 (ii) formed and maintained in good faith for a purpose other than obtaining insurance;

3142 and

3143 (d) may be issued only to:

3144 (i) a common carrier or an operator, owner, or lessee of a means of transportation, as  
3145 policyholder, covering persons who may become passengers as defined by reference to the  
3146 person's travel status;

3147 (ii) an employer, as policyholder, covering any group of employees, dependents, or  
3148 guests, as defined by reference to specified hazards incident to any activities of the  
3149 policyholder;

3150 (iii) an institution of learning, including a school district, a school jurisdictional unit, or  
3151 the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering  
3152 students, teachers, or employees;

3153 (iv) a religious, charitable, recreational, educational, or civic organization, or branch of  
3154 one of those organizations, as policyholder, covering a group of members or participants as  
3155 defined by reference to specified hazards incident to the activities sponsored or supervised by  
3156 the policyholder;

3157 (v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering  
3158 members, campers, employees, officials, or supervisors;

3159 (vi) a volunteer fire department, first aid, civil defense, or other similar volunteer  
3160 organization, as policyholder, covering a group of members or participants as defined by  
3161 reference to specified hazards incident to activities sponsored, supervised, or participated in by  
3162 the policyholder;

3163 (vii) a newspaper or other publisher, as policyholder, covering its carriers;

3164 (viii) an association, including a labor union, that has a constitution and bylaws and  
3165 that is organized in good faith for purposes other than that of obtaining insurance, as  
3166 policyholder, covering a group of members or participants as defined by reference to specified  
3167 hazards incident to the activities or operations sponsored or supervised by the policyholder; and

3168 (ix) any other class of risks that, in the judgment of the commissioner, may be properly  
3169 eligible for blanket accident and health insurance.

3170 (4) The judgment of the commissioner may be exercised on the basis of:

3171 (a) individual risks;

3172 (b) a class of risks; or

3173 (c) both Subsections (4)(a) and (b).

3174 Section 24. Section **31A-22-722** is amended to read:

3175 **31A-22-722. Utah mini-COBRA benefits for employer group coverage.**

3176 (1) An insured may extend the employee's coverage under the current employer's group  
3177 policy for a period of 12 months, except as provided in [~~Subsections (2) and 31A-22-722.5(4)~~]  
3178 Subsection (2). The right to extend coverage includes:

3179 (a) voluntary termination;

3180 (b) involuntary termination;

3181 (c) retirement;

3182 (d) death;

3183 (e) divorce or legal separation;

3184 (f) loss of dependent status;

3185 (g) sabbatical;

3186 (h) a disability;

3187 (i) leave of absence; or

- 3188 (j) reduction of hours.
- 3189 (2) (a) Notwithstanding Subsection (1), an employee may not extend coverage under  
3190 the current employer's group insurance policy if the employee:
- 3191 (i) fails to pay premiums or contributions in accordance with the terms of the insurance  
3192 policy;
- 3193 (ii) acquires other group coverage covering all preexisting conditions including  
3194 maternity, if the coverage exists;
- 3195 (iii) performs an act or practice that constitutes fraud in connection with the coverage;
- 3196 (iv) makes an intentional misrepresentation of material fact under the terms of the  
3197 coverage;
- 3198 (v) is terminated from employment for gross misconduct;
- 3199 (vi) is not continuously covered under the current employer's group policy for a period  
3200 of three months immediately before the termination of the insurance policy due to an event set  
3201 forth in Subsection (1);
- 3202 (vii) is eligible for an extension of coverage required by federal law;
- 3203 (viii) establishes residence outside of this state;
- 3204 (ix) moves out of the insurer's service area;
- 3205 (x) is eligible for similar coverage under another group insurance policy; or
- 3206 (xi) has the employee's coverage terminated because the employer's coverage is  
3207 terminated, except as provided in Subsection (8).
- 3208 (b) The right to extend coverage under Subsection (1) applies to spouse or dependent  
3209 coverage, including a surviving spouse or dependents whose coverage under the insurance  
3210 policy terminates by reason of the death of the employee or member.
- 3211 (3) (a) The employer shall notify the following in writing of the right to extend group  
3212 coverage and the payment amounts required for extension of coverage, including the manner,  
3213 place, and time in which the payments shall be made:
- 3214 (i) a terminated insured;
- 3215 (ii) an ex-spouse of an insured; or
- 3216 (iii) if Subsection (2)(b) applies:
- 3217 (A) a surviving spouse; and
- 3218 (B) the guardian of surviving dependents, if different from a surviving spouse.

3219 (b) The notification required in Subsection (3)(a) shall be sent first class mail within 30  
3220 days after the termination date of the group coverage to:

3221 (i) the terminated insured's home address as shown on the records of the employer;

3222 (ii) the address of the surviving spouse, if different from the insured's address and if  
3223 shown on the records of the employer;

3224 (iii) the guardian of any dependents address, if different from the insured's address, and  
3225 if shown on the records of the employer; and

3226 (iv) the address of the ex-spouse, if shown on the records of the employer.

3227 (4) The insurer shall provide the employee, spouse, or any eligible dependent the  
3228 opportunity to extend the group coverage at the payment amount stated in Subsection (5) if:

3229 (a) the employer policyholder does not provide the terminated insured the written  
3230 notification required by Subsection (3)(a); and

3231 (b) the employee or other individual eligible for extension contacts the insurer within  
3232 60 days of coverage termination.

3233 (5) (a) A premium amount for extended group coverage may not exceed 102% of the  
3234 group rate in effect for a group member, including an employer's contribution, if any, for a  
3235 group insurance policy.

3236 (b) Except as provided in Subsection (5)(a), an insurer may not charge an insured an  
3237 additional fee, an additional premium, interest, or any similar charge for electing extended  
3238 group coverage.

3239 (6) Except as provided in this Subsection (6), coverage extends without interruption for  
3240 12 months and may not terminate if the terminated insured or, with respect to a minor, the  
3241 parent or guardian of the terminated insured:

3242 (a) elects to extend group coverage within 60 days of losing group coverage; and

3243 (b) tenders the amount required to the employer or insurer.

3244 (7) The insured's coverage may be terminated before 12 months if the terminated  
3245 insured:

3246 (a) establishes residence outside of this state;

3247 (b) moves out of the insurer's service area;

3248 (c) fails to pay premiums or contributions in accordance with the terms of the insurance  
3249 policy, including any timeliness requirements;

3250 (d) performs an act or practice that constitutes fraud in connection with the coverage;

3251 (e) makes an intentional misrepresentation of material fact under the terms of the  
3252 coverage;

3253 (f) becomes eligible for similar coverage under another group insurance policy; or

3254 (g) has the coverage terminated because the employer's coverage is terminated, except  
3255 as provided in Subsection (8).

3256 (8) If the current employer coverage is terminated and the employer replaces coverage  
3257 with similar coverage under another group insurance policy, without interruption, the  
3258 terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection  
3259 (2)(b) applies, may obtain extension of coverage under the replacement group insurance policy:

3260 (a) for the balance of the period the terminated insured would have extended coverage  
3261 under the replaced group insurance policy; and

3262 (b) if the terminated insured is otherwise eligible for extension of coverage.

3263 (9) An insurer shall require an insured employer to offer to the following individuals an  
3264 open enrollment period at the same time as other regular employees:

3265 (a) an individual who extends group coverage and is current on payment; and

3266 (b) during the applicable grace period described in Subsection (3) or (4), an individual  
3267 who is eligible to elect to extend group coverage.

3268 Section 25. Section **31A-23a-107** is amended to read:

3269 **31A-23a-107. Character requirements.**

3270 An applicant for a license under this chapter shall show to the commissioner that:

3271 (1) the applicant has the intent in good faith, to engage in the type of business that the  
3272 license applied for would permit;

3273 (2) (a) if a natural person, the applicant is;

3274 (i) competent; and

3275 (ii) trustworthy; or

3276 (b) if the applicant is an agency:

3277 (i) the partners, directors, or principal officers or persons having comparable powers  
3278 are trustworthy; and

3279 (ii) that it will transact business in such a way that the acts that may only be performed  
3280 by a licensed producer, surplus lines producer, limited line producer, consultant, managing

3281 general agent, or reinsurance intermediary are performed exclusively by natural persons who  
3282 are licensed under this chapter to transact that type of business and designated on the agency's  
3283 license;

3284 (3) the applicant intends to comply with Section 31A-23a-502; and

3285 (4) if a natural person, the applicant is at least 18 years of age.

3286 Section 26. Section 31A-23a-109 is amended to read:

3287 **31A-23a-109. Nonresident jurisdictional agreement.**

3288 (1) (a) If a nonresident license applicant has a valid producer, surplus lines producer,  
3289 limited line producer, consultant, managing general agent, or reinsurance intermediary license  
3290 from the nonresident license applicant's home state or designated home state and the conditions  
3291 of Subsection (1)(b) are met, the commissioner shall:

3292 (i) waive the license requirements for a license under this chapter; and

3293 (ii) issue the nonresident license applicant a nonresident license.

3294 (b) Subsection (1)(a) applies if:

3295 (i) the nonresident license applicant:

3296 (A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or  
3297 designated home state at the time the nonresident license applicant applies for a nonresident  
3298 producer, surplus lines producer, limited line producer, consultant, managing general agent, or  
3299 reinsurance intermediary license;

3300 (B) has submitted the proper request for licensure;

3301 (C) has submitted to the commissioner:

3302 (I) the application for licensure that the nonresident license applicant submitted to the  
3303 applicant's home state or designated home state; or

3304 (II) a completed uniform application; and

3305 (D) has paid the applicable fees under Section 31A-3-103; and

3306 (ii) the nonresident license applicant's license in the applicant's home state or  
3307 designated home state is in good standing.

3308 (2) A nonresident applicant applying under Subsection (1) shall in addition to  
3309 complying with all license requirements for a license under this chapter execute, in a form  
3310 acceptable to the commissioner, an agreement to be subject to the jurisdiction of the Utah  
3311 commissioner and courts on any matter related to the applicant's insurance activities in this

3312 state, on the basis of:

3313 (a) service of process under Sections 31A-2-309 and 31A-2-310; or

3314 (b) service authorized:

3315 (i) in the Utah Rules of Civil Procedure; or

3316 (ii) under Section 78B-3-206.

3317 (3) The commissioner may verify a producer's licensing status through the producer

3318 database maintained by:

3319 (a) the National Association of Insurance Commissioners; or

3320 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

3321 (4) The commissioner may not assess a greater fee for an insurance license or related

3322 service to a person not residing in this state solely on the fact that the person does not reside in

3323 this state.

3324 Section 27. Section 31A-23a-111 is amended to read:

3325 **31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
3326 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**

3327 (1) A license type issued under this chapter remains in force until:

3328 (a) revoked or suspended under Subsection (5);

3329 (b) surrendered to the commissioner and accepted by the commissioner in lieu of

3330 administrative action;

3331 (c) the licensee dies or is adjudicated incompetent as defined under:

3332 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3333 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and

3334 Minors;

3335 (d) lapsed under Section 31A-23a-113; or

3336 (e) voluntarily surrendered.

3337 (2) The following may be reinstated within one year after the day on which the license

3338 is no longer in force:

3339 (a) a lapsed license; or

3340 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may

3341 not be reinstated after the license period in which the license is voluntarily surrendered.

3342 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a

3343 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
3344 department from pursuing additional disciplinary or other action authorized under:

3345 (a) this title; or

3346 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah

3347 Administrative Rulemaking Act.

3348 (4) A line of authority issued under this chapter remains in force until:

3349 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;

3350 or

3351 (b) the supporting license type:

3352 (i) is revoked or suspended under Subsection (5);

3353 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of

3354 administrative action;

3355 (iii) lapses under Section [31A-23a-113](#); or

3356 (iv) is voluntarily surrendered; or

3357 (c) the licensee dies or is adjudicated incompetent as defined under:

3358 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3359 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and

3360 Minors.

3361 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an

3362 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the

3363 commissioner may:

3364 (i) revoke:

3365 (A) a license; or

3366 (B) a line of authority;

3367 (ii) suspend for a specified period of 12 months or less:

3368 (A) a license; or

3369 (B) a line of authority;

3370 (iii) limit in whole or in part:

3371 (A) a license; or

3372 (B) a line of authority;

3373 (iv) deny a license application;

- 3374 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or  
3375 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and  
3376 Subsection (5)(a)(v).
- 3377 (b) The commissioner may take an action described in Subsection (5)(a) if the  
3378 commissioner finds that the licensee:
- 3379 (i) is unqualified for a license or line of authority under Section 31A-23a-104,  
3380 31A-23a-105, or 31A-23a-107;
- 3381 (ii) violates:
- 3382 (A) an insurance statute;
- 3383 (B) a rule that is valid under Subsection 31A-2-201(3); or  
3384 (C) an order that is valid under Subsection 31A-2-201(4);
- 3385 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other  
3386 delinquency proceedings in any state;
- 3387 (iv) fails to pay a final judgment rendered against the person in this state within 60  
3388 days after the day on which the judgment became final;
- 3389 (v) fails to meet the same good faith obligations in claims settlement that is required of  
3390 admitted insurers;
- 3391 (vi) is affiliated with and under the same general management or interlocking  
3392 directorate or ownership as another insurance producer that transacts business in this state  
3393 without a license;
- 3394 (vii) refuses:
- 3395 (A) to be examined; or  
3396 (B) to produce its accounts, records, and files for examination;
- 3397 (viii) has an officer who refuses to:
- 3398 (A) give information with respect to the insurance producer's affairs; or  
3399 (B) perform any other legal obligation as to an examination;
- 3400 (ix) provides information in the license application that is:
- 3401 (A) incorrect;
- 3402 (B) misleading;
- 3403 (C) incomplete; or  
3404 (D) materially untrue;

- 3405 (x) violates an insurance law, valid rule, or valid order of another regulatory agency in  
3406 any jurisdiction;
- 3407 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
- 3408 (xii) improperly withholds, misappropriates, or converts money or properties received  
3409 in the course of doing insurance business;
- 3410 (xiii) intentionally misrepresents the terms of an actual or proposed:
- 3411 (A) insurance contract;
- 3412 (B) application for insurance; or
- 3413 (C) life settlement;
- 3414 (xiv) is convicted of:
- 3415 (A) a felony; or
- 3416 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
- 3417 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
- 3418 (xvi) in the conduct of business in this state or elsewhere:
- 3419 (A) uses fraudulent, coercive, or dishonest practices; or
- 3420 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
- 3421 (xvii) has had an insurance license or other professional or occupational license, or [its]  
3422 an equivalent[;] to an insurance license or other professional or occupational license:
- 3423 (A) denied[;];
- 3424 (B) suspended[; or];
- 3425 (C) revoked [in another state, province, district, or territory]; or
- 3426 (D) surrendered to resolve an administrative action;
- 3427 (xviii) forges another's name to:
- 3428 (A) an application for insurance; or
- 3429 (B) a document related to an insurance transaction;
- 3430 (xix) improperly uses notes or another reference material to complete an examination  
3431 for an insurance license;
- 3432 (xx) knowingly accepts insurance business from an individual who is not licensed;
- 3433 (xxi) fails to comply with an administrative or court order imposing a child support  
3434 obligation;
- 3435 (xxii) fails to:

- 3436 (A) pay state income tax; or
- 3437 (B) comply with an administrative or court order directing payment of state income
- 3438 tax;
- 3439 (xxiii) violates or permits others to violate the federal Violent Crime Control and Law
- 3440 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
- 3441 prohibited from engaging in the business of insurance; or
- 3442 (xxiv) engages in a method or practice in the conduct of business that endangers the
- 3443 legitimate interests of customers and the public.
- 3444 (c) For purposes of this section, if a license is held by an agency, both the agency itself
- 3445 and any individual designated under the license are considered to be the holders of the license.
- 3446 (d) If an individual designated under the agency license commits an act or fails to
- 3447 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
- 3448 the commissioner may suspend, revoke, or limit the license of:
- 3449 (i) the individual;
- 3450 (ii) the agency, if the agency:
- 3451 (A) is reckless or negligent in its supervision of the individual; or
- 3452 (B) knowingly participates in the act or failure to act that is the ground for suspending,
- 3453 revoking, or limiting the license; or
- 3454 (iii) (A) the individual; and
- 3455 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
- 3456 (6) A licensee under this chapter is subject to the penalties for acting as a licensee
- 3457 without a license if:
- 3458 (a) the licensee's license is:
- 3459 (i) revoked;
- 3460 (ii) suspended;
- 3461 (iii) limited;
- 3462 (iv) surrendered in lieu of administrative action;
- 3463 (v) lapsed; or
- 3464 (vi) voluntarily surrendered; and
- 3465 (b) the licensee:
- 3466 (i) continues to act as a licensee; or

3467 (ii) violates the terms of the license limitation.

3468 (7) A licensee under this chapter shall immediately report to the commissioner:

3469 (a) a revocation, suspension, or limitation of the person's license in another state, the  
3470 District of Columbia, or a territory of the United States;

3471 (b) the imposition of a disciplinary sanction imposed on that person by another state,  
3472 the District of Columbia, or a territory of the United States; or

3473 (c) a judgment or injunction entered against that person on the basis of conduct  
3474 involving:

3475 (i) fraud;

3476 (ii) deceit;

3477 (iii) misrepresentation; or

3478 (iv) a violation of an insurance law or rule.

3479 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a  
3480 license in lieu of administrative action may specify a time, not to exceed five years, within  
3481 which the former licensee may not apply for a new license.

3482 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the  
3483 former licensee may not apply for a new license for five years from the day on which the order  
3484 or agreement is made without the express approval by the commissioner.

3485 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
3486 a license issued under this part if so ordered by a court.

3487 (10) The commissioner shall by rule prescribe the license renewal and reinstatement  
3488 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3489 Section 28. Section **31A-23a-208** is amended to read:

3490 **31A-23a-208. Producer and agency authority in health insurance exchange.**

3491 A producer or agency licensed under this chapter, with a line of authority that permits  
3492 the producer or agency to sell, negotiate, or solicit accident and health insurance, is authorized  
3493 to sell, negotiate, or solicit qualified health plans offered on ~~[an]~~ a health insurance exchange  
3494 ~~[that is:]~~.

3495 ~~[(1) operated in the state; or]~~

3496 ~~[(2) operated in the state and certified by the United States Department of Health and~~  
3497 ~~Human Services as a:]~~

3498 ~~[(a) state-based exchange under PPACA;]~~

3499 ~~[(b) a federally facilitated exchange under PPACA; or]~~

3500 ~~[(c) a partnership exchange under PPACA.]~~

3501 Section 29. Section **31A-23a-406** is amended to read:

3502 **31A-23a-406. Title insurance producer's business.**

3503 (1) An individual title insurance producer or agency title insurance producer may do  
3504 escrow involving real property transactions if all of the following exist:

3505 (a) the individual title insurance producer or agency title insurance producer is licensed  
3506 with:

3507 (i) the title line of authority; and

3508 (ii) the escrow subline of authority;

3509 (b) the individual title insurance producer or agency title insurance producer is  
3510 appointed by a title insurer authorized to do business in the state;

3511 (c) the individual title insurance producer or agency title insurance producer issues one  
3512 or more of the following as part of the transaction:

3513 (i) an owner's policy of title insurance; ~~[or]~~

3514 (ii) a lender's policy of title insurance; or

3515 (iii) if the transaction does not involve a transfer of ownership, an endorsement to an  
3516 owner's or a lender's policy of title insurance.

3517 (d) money deposited with the individual title insurance producer or agency title  
3518 insurance producer in connection with any escrow:

3519 (i) is deposited:

3520 (A) in a federally insured financial institution; and

3521 (B) in a trust account that is separate from all other trust account money that is not  
3522 related to real estate transactions;

3523 (ii) is the property of the one or more persons entitled to the money under the  
3524 provisions of the escrow; and

3525 (iii) is segregated escrow by escrow in the records of the individual title insurance  
3526 producer or agency title insurance producer;

3527 (e) earnings on money held in escrow may be paid out of the escrow account to any  
3528 person in accordance with the conditions of the escrow;

3529 (f) the escrow does not require the individual title insurance producer or agency title  
3530 insurance producer to hold:

3531 (i) construction money; or

3532 (ii) money held for exchange under Section 1031, Internal Revenue Code; and

3533 (g) the individual title insurance producer or agency title insurance producer shall  
3534 maintain a physical office in Utah staffed by a person with an escrow subline of authority who  
3535 processes the escrow.

3536 (2) Notwithstanding Subsection (1), an individual title insurance producer or agency  
3537 title insurance producer may engage in the escrow business if:

3538 (a) the escrow involves:

3539 (i) a mobile home;

3540 (ii) a grazing right;

3541 (iii) a water right; or

3542 (iv) other personal property authorized by the commissioner; and

3543 (b) the individual title insurance producer or agency title insurance producer complies  
3544 with this section except for Subsection (1)(c).

3545 (3) Money held in escrow:

3546 (a) is not subject to any debts of the individual title insurance producer or agency title  
3547 insurance producer;

3548 (b) may only be used to fulfill the terms of the individual escrow under which the  
3549 money is accepted; and

3550 (c) may not be used until the conditions of the escrow are met.

3551 (4) Assets or property other than escrow money received by an individual title  
3552 insurance producer or agency title insurance producer in accordance with an escrow shall be  
3553 maintained in a manner that will:

3554 (a) reasonably preserve and protect the asset or property from loss, theft, or damages;  
3555 and

3556 (b) otherwise comply with the general duties and responsibilities of a fiduciary or  
3557 bailee.

3558 (5) (a) A check from the trust account described in Subsection (1)(d) may not be  
3559 drawn, executed, or dated, or money otherwise disbursed unless the segregated escrow account

3560 from which money is to be disbursed contains a sufficient credit balance consisting of collected  
3561 and cleared money at the time the check is drawn, executed, or dated, or money is otherwise  
3562 disbursed.

3563 (b) As used in this Subsection (5), money is considered to be "collected and cleared,"  
3564 and may be disbursed as follows:

3565 (i) cash may be disbursed on the same day the cash is deposited;

3566 (ii) a wire transfer may be disbursed on the same day the wire transfer is deposited; and

3567 (iii) the proceeds of one or more of the following financial instruments may be  
3568 disbursed on the same day the financial instruments are deposited if received from a single  
3569 party to the real estate transaction and if the aggregate of the financial instruments for the real  
3570 estate transaction is less than \$10,000:

3571 (A) a cashier's check, certified check, or official check that is drawn on an existing  
3572 account at a federally insured financial institution;

3573 (B) a check drawn on the trust account of a principal broker or associate broker  
3574 licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the individual  
3575 title insurance producer or agency title insurance producer has reasonable and prudent grounds  
3576 to believe sufficient money will be available from the trust account on which the check is  
3577 drawn at the time of disbursement of proceeds from the individual title insurance producer or  
3578 agency title insurance producer's escrow account;

3579 (C) a personal check not to exceed \$500 per closing; or

3580 (D) a check drawn on the escrow account of another individual title insurance producer  
3581 or agency title insurance producer, if the individual title insurance producer or agency title  
3582 insurance producer in the escrow transaction has reasonable and prudent grounds to believe  
3583 that sufficient money will be available for withdrawal from the account upon which the check  
3584 is drawn at the time of disbursement of money from the escrow account of the individual title  
3585 insurance producer or agency title insurance producer in the escrow transaction.

3586 (c) A check or deposit not described in Subsection (5)(b) may be disbursed:

3587 (i) within the time limits provided under the Expedited Funds Availability Act, 12  
3588 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

3589 (ii) upon notification from the financial institution to which the money has been  
3590 deposited that final settlement has occurred on the deposited financial instrument.

3591 (6) An individual title insurance producer or agency title insurance producer shall  
3592 maintain a record of a receipt or disbursement of escrow money.

3593 (7) An individual title insurance producer or agency title insurance producer shall  
3594 comply with:

3595 (a) Section 31A-23a-409;

3596 (b) Title 46, Chapter 1, Notaries Public Reform Act; and

3597 (c) any rules adopted by the Title and Escrow Commission, subject to Section  
3598 31A-2-404, that govern escrows.

3599 (8) If an individual title insurance producer or agency title insurance producer conducts  
3600 a search for real estate located in the state, the individual title insurance producer or agency  
3601 title insurance producer shall conduct a reasonable search of the public records.

3602 Section 30. Section 31A-23b-102 is amended to read:

3603 **31A-23b-102. Definitions.**

3604 As used in this chapter:

3605 (1) "Enroll" and "enrollment" mean to:

3606 (a) (i) obtain personally identifiable information about an individual; and

3607 (ii) inform an individual about accident and health insurance plans or public programs  
3608 offered on an exchange;

3609 (b) solicit insurance; or

3610 (c) submit to the exchange:

3611 (i) personally identifiable information about an individual; and

3612 (ii) an individual's selection of a particular accident and health insurance plan or public  
3613 program offered on the exchange.

3614 ~~[(2)(a) "Exchange" means an online marketplace that is certified by the United States  
3615 Department of Health and Human Services as either a state-based small employer exchange or  
3616 a federally facilitated individual exchange under PPACA.]~~

3617 ~~[(b) "Exchange" does not include an online marketplace for the purchase of health  
3618 insurance if the online marketplace is not a certified exchange in accordance with Subsection  
3619 (2)(a).]~~

3620 ~~[(3)]~~ (2) "Navigator":

3621 (a) means a person who facilitates enrollment in an exchange by offering to assist, or

3622 who advertises any services to assist, with:

3623 (i) the selection of and enrollment in a qualified health plan or a public program  
3624 offered on an exchange; or

3625 (ii) applying for premium subsidies through an exchange; and

3626 (b) includes a person who is an in-person assister or a certified application counselor as  
3627 described in federal regulations or guidance issued under PPACA.

3628 [~~(4)~~] (3) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

3629 [~~(5)~~] (4) "Public programs" means the state Medicaid program in Title 26, Chapter 18,  
3630 Medical Assistance Act, and Title 26, Chapter 40, Utah Children's Health Insurance Act.

3631 [~~(6)~~] (5) "Resident" is as defined by rule made by the commissioner in accordance with  
3632 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3633 [~~(7)~~] (6) "Solicit" [~~is as~~] means the same as that term is defined in Section  
3634 [31A-23a-102](#).

3635 Section 31. Section **31A-23b-202.5** is amended to read:

3636 **31A-23b-202.5. License types.**

3637 (1) A license issued under this chapter shall be issued under the license types described  
3638 in Subsection (2).

3639 (2) A license type under this chapter shall be a navigator line of authority or a certified  
3640 application counselor line of authority. A license type is intended to describe the matters to be  
3641 considered under any education, examination, and training required of an applicant under this  
3642 chapter.

3643 (3) (a) A navigator line of authority includes the enrollment process as described in  
3644 Subsection [31A-23b-102](#)[~~(3)~~](2)(a).

3645 (b) (i) A certified application counselor line of authority is limited to providing  
3646 information and assistance to individuals and employees about public programs and premium  
3647 subsidies available through the exchange.

3648 (ii) A certified application counselor line of authority does not allow the certified  
3649 application counselor to assist a person with the selection of or enrollment in a qualified health  
3650 plan offered on an exchange.

3651 Section 32. Section **31A-23b-204** is amended to read:

3652 **31A-23b-204. Character requirements.**

3653 An applicant for a license under this chapter shall demonstrate to the commissioner  
3654 that:

3655 (1) the applicant has the intent, in good faith, to engage in the practice of a navigator as  
3656 the license would permit;

3657 (2) (a) if a natural person, the applicant is:

3658 (i) competent; and

3659 (ii) trustworthy; or

3660 (b) if the applicant is an agency:

3661 (i) the partners, directors, or principal officers or persons having comparable powers  
3662 are trustworthy; and

3663 (ii) that it will transact business in a way that the acts that may only be performed by a  
3664 licensed navigator are performed only by a natural person who is licensed under this chapter, or  
3665 Chapter 23a, Insurance Marketing-Licensing Producers, Consultants, and Reinsurance  
3666 Intermediaries;

3667 (3) the applicant intends to comply with the surety bond requirements of Section  
3668 [31A-23b-207](#);

3669 (4) if a natural person, the applicant is at least 18 years of age; and

3670 (5) the applicant does not have a conflict of interest as defined by regulations issued  
3671 under PPACA.

3672 Section 33. Section **31A-23b-205** is amended to read:

3673 **31A-23b-205. Examination and training requirements.**

3674 (1) The commissioner may require an applicant for a license to pass an examination  
3675 and complete a training program as a requirement for a license.

3676 (2) The examination described in Subsection (1) shall reasonably relate to:

3677 (a) the duties and functions of a navigator;

3678 (b) requirements for navigators as established by federal regulation under PPACA; and

3679 (c) other requirements that may be established by the commissioner by administrative  
3680 rule.

3681 (3) The examination may be administered by the commissioner or as otherwise  
3682 specified by administrative rule.

3683 (4) The training required by Subsection (1) shall be approved by the commissioner and

3684 shall include:

- 3685 (a) accident and health insurance plans;
- 3686 (b) qualifications for and enrollment in public programs;
- 3687 (c) qualifications for and enrollment in premium subsidies;
- 3688 (d) cultural and linguistic competence;
- 3689 (e) conflict of interest standards;
- 3690 (f) exchange functions; and
- 3691 (g) other requirements that may be adopted by the commissioner by administrative

3692 rule.

3693 (5) (a) For the navigator line of authority, the training required by Subsection (1) shall  
3694 consist of at least 21 credit hours of training before obtaining the license, which shall  
3695 include~~[(i) at least two hours of training on defined contribution arrangements and the small~~  
3696 ~~employer health insurance exchange; and (ii)]~~ the navigator training and certification program  
3697 developed by the Centers for Medicare and Medicaid Services.

3698 (b) For the certified application counselor line of authority, the training required by  
3699 Subsection (1) shall consist of at least six hours of training before obtaining a license, which  
3700 shall include~~[(i) at least one hour of training on defined contribution arrangements and the~~  
3701 ~~small employer health insurance exchange; and (ii)]~~ the certified application counselor training  
3702 and certification program developed by the Centers for Medicare and Medicaid Services.

3703 (6) This section applies only to an applicant who is a natural person.

3704 Section 34. Section **31A-23b-206** is amended to read:

3705 **31A-23b-206. Continuing education requirements.**

3706 (1) The commissioner shall, by rule, prescribe continuing education requirements for a  
3707 navigator.

3708 (2) (a) The commissioner may not require a degree from an institution of higher  
3709 education as part of continuing education.

3710 (b) The commissioner may state a continuing education requirement in terms of hours  
3711 of instruction received in:

- 3712 (i) accident and health insurance;
- 3713 (ii) qualification for and enrollment in public programs;
- 3714 (iii) qualification for and enrollment in premium subsidies;

3715 (iv) cultural competency;

3716 (v) conflict of interest standards; and

3717 (vi) other exchange functions.

3718 (3) (a) For a navigator line of authority, continuing education requirements shall

3719 require:

3720 (i) that a licensee complete 12 credit hours of continuing education for every one-year

3721 licensing period;

3722 (ii) that at least two of the 12 credit hours described in Subsection (3)(a)(i) be ethics

3723 courses; and

3724 [~~(iii) that at least one of the 12 credit hours described in Subsection (3)(a)(i) be training~~

3725 ~~on defined contribution arrangements and the use of the small employer health insurance~~

3726 ~~exchange; and]~~

3727 [(iv)] (iii) that a licensee complete the annual navigator training and certification

3728 program developed by the Centers for Medicare and Medicaid Services.

3729 (b) For a certified application counselor, the continuing education requirements shall

3730 require:

3731 (i) that a licensee complete six credit hours of continuing education for every one-year

3732 licensing period;

3733 (ii) that at least two of the six credit hours described in Subsection (3)(b)(i) be on

3734 ethics courses; and

3735 [~~(iii) that at least one of the six credit hours described in Subsection (3)(b)(i) be~~

3736 ~~training on defined contribution arrangements and the use of the small employer health~~

3737 ~~insurance exchange; and]~~

3738 [(iv)] (iii) that a licensee complete the annual certified application counselor training

3739 and certification program developed by the Centers for Medicare and Medicaid Services.

3740 (c) An hour of continuing education in accordance with Subsections (3)(a)(i) and (b)(i)

3741 may be obtained through:

3742 (i) classroom attendance;

3743 (ii) home study;

3744 (iii) watching a video recording; or

3745 (iv) another method approved by rule.

3746 (d) A licensee may obtain continuing education hours at any time during the one-year  
3747 license period.

3748 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
3749 commissioner shall, by rule, authorize one or more continuing education providers, including a  
3750 state or national professional producer or consultant associations, to:

3751 (i) offer a qualified program on a geographically accessible basis; and

3752 (ii) collect a reasonable fee for funding and administration of a continuing education  
3753 program, subject to the review and approval of the commissioner.

3754 (4) The commissioner shall approve a continuing education provider or a continuing  
3755 education course that satisfies the requirements of this section.

3756 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
3757 commissioner shall by rule establish the procedures for continuing education provider  
3758 registration and course approval.

3759 (6) This section applies only to a navigator who is a natural person.

3760 (7) A navigator shall keep documentation of completing the continuing education  
3761 requirements of this section for one year after the end of the one-year licensing period to which  
3762 the continuing education applies.

3763 Section 35. Section **31A-25-204** is amended to read:

3764 **31A-25-204. Character requirements.**

3765 Each applicant for a license under this chapter shall show to the commissioner all of the  
3766 following:

3767 (1) ~~[he or it]~~ that the applicant has the good faith intent to engage in the type of  
3768 business the license applied for would permit;

3769 (2) (a) if a natural person, ~~[he is]~~ that the applicant is:

3770 (i) competent; and

3771 (ii) trustworthy~~;~~; or~~;~~

3772 (b) if a partnership or corporation, that all the partners, directors, principal officers, or  
3773 persons having comparable powers are trustworthy; and

3774 (3) if a natural person, ~~[he]~~ that the applicant is at least 18 years of age.

3775 Section 36. Section **31A-25-206** is amended to read:

3776 **31A-25-206. Nonresident jurisdictional agreement.**

3777 (1) (a) If a nonresident license applicant has a valid license from the nonresident license  
3778 applicant's home state or designated home state and the conditions of Subsection (1)(b) are  
3779 met, the commissioner shall:

3780 (i) waive any license requirement for a license under this chapter; and

3781 (ii) issue the nonresident license applicant a nonresident third party administrator  
3782 license.

3783 (b) Subsection (1)(a) applies if:

3784 (i) the nonresident license applicant:

3785 (A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or  
3786 designated home state at the time the nonresident license applicant applies for a nonresident  
3787 third party administrator license;

3788 (B) has submitted the proper request for licensure;

3789 (C) has submitted to the commissioner:

3790 (I) the application for licensure that the nonresident license applicant submitted to the  
3791 applicant's home state or designated home state; or

3792 (II) a completed uniform application; and

3793 (D) has paid the applicable fees under Section 31A-3-103;

3794 (ii) the nonresident license applicant's license in the applicant's home state or  
3795 designated home state is in good standing; and

3796 (iii) the nonresident license applicant's home state or designated home state awards  
3797 nonresident third party administrator licenses to residents of this state on the same basis as this  
3798 state awards licenses to residents of that home state or designated home state.

3799 (2) A nonresident applicant shall execute in a form acceptable to the commissioner an  
3800 agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter  
3801 related to the applicant's insurance activities in Utah, on the basis of:

3802 (a) service of process under Sections 31A-2-309 and 31A-2-310; or

3803 (b) other service authorized in the Utah Rules of Civil Procedure.

3804 (3) The commissioner may verify the third party administrator's licensing status  
3805 through the database maintained by:

3806 (a) the National Association of Insurance Commissioners; or

3807 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

3808 (4) The commissioner may not assess a greater fee for an insurance license or related  
3809 service to a person not residing in this state based solely on the fact that the person does not  
3810 reside in this state.

3811 Section 37. Section **31A-26-102** is amended to read:

3812 **31A-26-102. Definitions.**

3813 As used in this chapter, unless expressly provided otherwise:

3814 (1) "Company adjuster" means a person employed by an insurer [~~whose regular duties~~  
3815 ~~include insurance adjusting~~], or an entity under common control or ownership with the insurer,  
3816 who negotiates or settles claims on behalf of the employer.

3817 (2) "Designated home state" means the state or territory of the United States or the  
3818 District of Columbia:

3819 (a) in which an insurance adjuster does not maintain the adjuster's principal:

3820 (i) place of residence; or

3821 (ii) place of business;

3822 (b) if the resident state, territory, or District of Columbia of the adjuster does not  
3823 license adjusters for the line of authority sought, the adjuster has qualified for the license as if  
3824 the person were a resident in the state, territory, or District of Columbia described in  
3825 Subsection (2)(a), including an applicable:

3826 (i) examination requirement;

3827 (ii) fingerprint background check requirement; and

3828 (iii) continuing education requirement; and

3829 (c) the adjuster has designated the state, territory, or District of Columbia as the  
3830 designated home state.

3831 (3) "Home state" means:

3832 (a) a state or territory of the United States or the District of Columbia in which an  
3833 insurance adjuster:

3834 (i) maintains the adjuster's principal:

3835 (A) place of residence; or

3836 (B) place of business; and

3837 (ii) is licensed to act as a resident adjuster; or

3838 (b) if the resident state, territory, or the District of Columbia described in Subsection

3839 (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District  
3840 of Columbia:

3841 (i) in which the adjuster is licensed;

3842 (ii) in which the adjuster is in good standing; and

3843 (iii) that the adjuster has designated as the adjuster's designated home state.

3844 (4) "Independent adjuster" means an insurance adjuster required to be licensed under  
3845 Section 31A-26-201, who engages in insurance adjusting as a representative of one or more  
3846 insurers.

3847 (5) "Insurance adjusting" or "adjusting" means directing or conducting the  
3848 investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an  
3849 insurer, policyholder, or a claimant under an insurance policy.

3850 (6) "Organization" means a person other than a natural person, and includes a sole  
3851 proprietorship by which a natural person does business under an assumed name.

3852 (7) "Portable electronics insurance" is as defined in Section 31A-22-1802.

3853 (8) "Public adjuster" means a person required to be licensed under Section  
3854 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants  
3855 under insurance policies.

3856 Section 38. Section 31A-26-205 is amended to read:

3857 **31A-26-205. Character requirements.**

3858 Each applicant for a license under this chapter shall show to the commissioner that:

3859 (1) ~~he~~ the applicant has the good faith intent to engage in the type of business the  
3860 license or licenses applied for would permit;

3861 (2) (a) if a natural person, ~~he is~~ the applicant is:

3862 (i) competent; and

3863 (ii) trustworthy~~;~~; or ~~that,~~

3864 (b) if an organization, all the partners, directors, principal officers, or persons in fact  
3865 having comparable powers are trustworthy, and that ~~it~~ the applicant will transact business in  
3866 such a way that all acts that may only be performed by a licensed adjuster are performed  
3867 exclusively by natural persons who are licensed under this chapter to transact that business and  
3868 listed on the organization's license under Section 31A-26-209; and

3869 (3) if a natural person, ~~he~~ the applicant is at least 18 years of age.

3870 Section 39. Section **31A-26-208** is amended to read:

3871 **31A-26-208. Nonresident jurisdictional agreement.**

3872 (1) (a) If a nonresident license applicant has a valid license from the nonresident  
3873 license applicant's home state or designated home state and the conditions of Subsection (1)(b)  
3874 are met, the commissioner shall:

3875 (i) waive any license requirement for a license under this chapter; and

3876 (ii) issue the nonresident license applicant a nonresident adjuster's license.

3877 (b) Subsection (1)(a) applies if:

3878 (i) the nonresident license applicant:

3879 (A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or  
3880 designated home state at the time the nonresident license applicant applies for a nonresident  
3881 adjuster license;

3882 (B) has submitted the proper request for licensure;

3883 (C) has submitted to the commissioner:

3884 (I) the application for licensure that the nonresident license applicant submitted to the  
3885 applicant's home state or designated home state; or

3886 (II) a completed uniform application; and

3887 (D) has paid the applicable fees under Section [31A-3-103](#);

3888 (ii) the nonresident license applicant's license in the applicant's home state or  
3889 designated home state is in good standing; and

3890 (iii) the nonresident license applicant's home state or designated home state awards  
3891 nonresident adjuster licenses to residents of this state on the same basis as this state awards  
3892 licenses to residents of that home state or designated home state.

3893 (2) A nonresident applicant shall execute in a form acceptable to the commissioner an  
3894 agreement to be subject to the jurisdiction of the commissioner and courts of this state on any  
3895 matter related to the adjuster's insurance activities in this state, on the basis of:

3896 (a) service of process under Sections [31A-2-309](#) and [31A-2-310](#); or

3897 (b) other service authorized under the Utah Rules of Civil Procedure or Section  
3898 [78B-3-206](#).

3899 (3) The commissioner may verify an adjuster's licensing status through the database  
3900 maintained by:

- 3901 (a) the National Association of Insurance Commissioners; or
- 3902 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
- 3903 (4) The commissioner may not assess a greater fee for an insurance license or related
- 3904 service to a person not residing in this state based solely on the fact that the person does not
- 3905 reside in this state.

3906 Section 40. Section **31A-27a-111** is amended to read:

3907 **31A-27a-111. Actions by and against the receiver.**

3908 (1) (a) An allegation by the receiver of improper or fraudulent conduct against a person

3909 may not be the basis of a defense to the enforcement of a contractual obligation owed to the

3910 insurer by a third party.

3911 (b) Notwithstanding Subsection (1)(a), a third party described in this Subsection (1) is

3912 not barred by this section from seeking to establish independently as a defense that the conduct

3913 is materially and substantially related to the contractual obligation for which enforcement is

3914 sought.

3915 (2) (a) Subject to Subsection (2)(b), a prior wrongful or negligent action of any present

3916 or former officer, manager, director, trustee, owner, employee, or agent of the insurer may not

3917 be asserted as a defense to a claim by the receiver:

3918 (i) under a theory of:

3919 (A) estoppel;

3920 (B) comparative fault;

3921 (C) intervening cause;

3922 (D) proximate cause;

3923 (E) reliance; or

3924 (F) mitigation of damages; or

3925 (ii) otherwise.

3926 (b) Notwithstanding Subsection (2)(a):

3927 (i) the affirmative defense of fraud in the inducement may be asserted against the

3928 receiver in a claim based on a contract; and

3929 (ii) a principal under a surety bond or a surety undertaking is entitled to credit against

3930 any reimbursement obligation to the receiver for the value of any property pledged to secure the

3931 reimbursement obligation to the extent that:

3932 (A) the receiver has possession or control of the property; or

3933 (B) the insurer or its agents misappropriated, including commingling, the property.

3934 (c) Evidence of fraud in the inducement is admissible only if it is contained in the  
3935 records of the insurer.

3936 (3) Action or inaction by an insurance regulatory authority may not be asserted as a  
3937 defense to a claim by the receiver.

3938 (4) (a) Subject to Subsection (4)(b), a judgment or order entered against an insured or  
3939 the insurer in contravention of a stay or injunction under this chapter, or at any time by default  
3940 or collusion, may not be considered as evidence of liability or of the quantum of damages in  
3941 adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.

3942 (b) Subsection (4)(a) does not apply to an affected guaranty association's claim for  
3943 amounts paid on a settlement or judgment in pursuit of the affected guaranty association's  
3944 statutory obligations.

3945 (5) (a) Subject to Subsection (5)(b), the following do not affect the amount that a  
3946 receiver may recover from a third party, regardless of any provision in an agreement to the  
3947 contrary:

3948 (i) the insurer's insolvency; or

3949 (ii) the insurer's or receiver's failure to pay all or a portion of an amount or a claim to  
3950 the third party.

3951 (b) If an agreement between the insurer and a third party requires a payment by the  
3952 insurer before the insurer may recover from the third party, the amount the receiver may  
3953 recover from the third party under Subsection (5)(a) is limited to an amount equal to the greater  
3954 of:

3955 (i) the amount paid by the insurer or by another person on behalf of the insurer to the  
3956 third party; or

3957 (ii) the amount allowed as a claim for payment under:

3958 (A) an approved report described in Section [31A-27a-608](#);

3959 (B) an order of the receivership court; or

3960 (C) a plan of rehabilitation.

3961 ~~[(5)]~~ (6) The receiver may not be considered a governmental entity for the purposes of  
3962 any state law awarding fees to a litigant who prevails against a governmental entity.

3963 Section 41. Section **31A-27a-608** is amended to read:

3964 **31A-27a-608. Liquidator's recommendations to the receivership court.**

3965 (1) The liquidator shall, from time to time as determined by the liquidator, present to  
3966 the receivership court for approval, reports of claims settled or determined by the liquidator  
3967 under Section [31A-27a-603](#).

3968 (2) A report required by this section shall include information identifying:

3969 (a) the claim;

3970 (b) the amount of the claim; and

3971 (c) the priority class of the claim.

3972 (3) (a) A claim included in a report described in this section and approved by the  
3973 receivership court is a liability of the estate.

3974 (b) An insurer's insolvency does not affect the amount of a liability described in  
3975 Subsection (3)(a), regardless of any provision in an agreement to the contrary.

3976 Section 42. Section **31A-30-210** is amended to read:

3977 **31A-30-210. State contract requirements -- Employer default plans.**

3978 (1) This section applies to an employer who is required to offer [its] the employer's  
3979 employees a health benefit plan as a condition of qualifying for a state contract under:

3980 (a) Section [17B-2a-818.5](#);

3981 (b) Section [19-1-206](#);

3982 [~~(c) Subsection [63A-5-205\(3\)](#);~~]

3983 (c) Subsection [63A-5-205.5](#);

3984 (d) Section [63C-9-403](#);

3985 (e) Section [72-6-107.5](#); and

3986 (f) Section [79-2-404](#).

3987 (2) An employer described in Subsection (1) shall, when selecting the default plan  
3988 required in Section [31A-30-204](#), select a default plan that is "qualified health insurance  
3989 coverage" as defined in the sections listed in Subsections (1)(a) through (f).

3990 Section 43. Section **31A-43-303** is amended to read:

3991 **31A-43-303. Stop-loss insurance disclosure.**

3992 A stop-loss insurance contract delivered, issued for delivery, or entered into shall  
3993 include the disclosure exhibit required by the commissioner through administrative rule, which

3994 shall include at least the following information:

- 3995 (1) the complete costs for the stop-loss contract;
- 3996 (2) the date on which the insurance takes effect and terminates, including renewability
- 3997 provisions;
- 3998 (3) the aggregate attachment point and the specific attachment point;
- 3999 (4) limitations on coverage;
- 4000 (5) an explanation of monthly accommodation and disclosure about any monthly
- 4001 accommodation features included in the stop-loss contract;
- 4002 (6) a description of terminal liability funding, including the cost of processing claims
- 4003 before and after the termination of the contract; ~~and~~
- 4004 (7) maximum claims liability to the employer[-]; and
- 4005 (8) a summary of the policy.

4006 Section 44. Section **31A-45-403** is enacted to read:

4007 **31A-45-403. Essential health benefits.**

4008 (1) The state designates the state's own essential health benefits and does not accept a

4009 federal determination of the essential health benefits under the PPACA.

4010 (2) Subject to Subsections (3) and (4), the commissioner shall make rules in

4011 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that designate the

4012 essential health benefits for the state.

4013 (3) Before the commissioner makes rules in accordance with Subsection (2):

4014 (a) the commissioner shall present a summary of the commissioner's planned rules to

4015 the Health Reform Task Force; and

4016 (b) the Health Reform Task Force shall recommend whether the commissioner makes

4017 rules in accordance with the presented summary.

4018 (4) The essential health benefits plan:

4019 (a) may not include a state mandate if the inclusion of the state mandate would require

4020 the state to contribute to premium subsidies under the PPACA; and

4021 (b) may add benefits in addition to the benefits included in a benchmark plan adopted

4022 in accordance with this section if the additional benefits are mandated under the PPACA.

4023 Section 45. Section **34A-2-107** is amended to read:

4024 **34A-2-107. Appointment of workers' compensation advisory council --**

4025 **Composition -- Terms of members -- Duties -- Compensation.**

4026 (1) The commissioner shall appoint a workers' compensation advisory council  
4027 composed of:

4028 (a) the following voting members:

4029 (i) five employer representatives; and

4030 (ii) five employee representatives; and

4031 (b) the following nonvoting members:

4032 (i) a representative of the workers' compensation insurance carrier that provides  
4033 workers' compensation insurance under Section [31A-22-1001](#);

4034 (ii) a representative of a workers' compensation insurance carrier different from the  
4035 workers' compensation insurance carrier listed in Subsection (1)(b)(i);

4036 (iii) a representative of health care providers;

4037 (iv) the Utah insurance commissioner or the insurance commissioner's designee; and

4038 (v) the commissioner or the commissioner's designee.

4039 (2) Employers and employees shall consider nominating members of groups who  
4040 historically may have been excluded from the council, such as women, minorities, and  
4041 individuals with disabilities.

4042 (3) (a) Except as required by Subsection (3)(b), as terms of current council members  
4043 expire, the commissioner shall appoint each new member or reappointed member to a two-year  
4044 term beginning July 1 and ending June 30.

4045 (b) Notwithstanding the requirements of Subsection (3)(a), the commissioner shall, at  
4046 the time of appointment or reappointment, adjust the length of terms to ensure that the terms of  
4047 council members are staggered so that approximately half of the council is appointed every two  
4048 years.

4049 (4) (a) When a vacancy occurs in the membership for any reason, the replacement shall  
4050 be appointed for the unexpired term.

4051 (b) The commissioner shall terminate the term of a council member who ceases to be  
4052 representative as designated by the member's original appointment.

4053 (5) The council shall confer at least quarterly for the purpose of advising the  
4054 commission, the division, and the Legislature on:

4055 (a) the Utah workers' compensation and occupational disease laws;

4056 (b) the administration of the laws described in Subsection (5)(a); and

4057 (c) rules related to the laws described in Subsection (5)(a).

4058 (6) Regarding workers' compensation, rehabilitation, and reemployment of employees  
4059 who acquire a disability because of an industrial injury or occupational disease the council  
4060 shall:

4061 (a) offer advice on issues requested by:

4062 (i) the commission;

4063 (ii) the division; and

4064 (iii) the Legislature; and

4065 (b) make recommendations to:

4066 (i) the commission; and

4067 (ii) the division.

4068 ~~[(7) The council shall study how hospital costs may be reduced for purposes of medical~~  
4069 ~~benefits for workers' compensation. By no later than November 30, 2017, the council shall~~  
4070 ~~submit, in accordance with Section 68-3-14, a written report to the Business and Labor Interim~~  
4071 ~~Committee containing the council's recommendations.]~~

4072 (7) (a) The council shall:

4073 (i) study how to reduce hospital costs for purposes of medical benefits for workers'  
4074 compensation;

4075 (ii) study hospital billing and payment trends in the state;

4076 (iii) study hospital fee schedules used in other states; and

4077 (iv) collect information from third-party hospital bill review companies in the state or  
4078 region to identify an average reimbursement rate that represents the approximate rate at which  
4079 a workers' compensation insurance carrier or self-insured employer should expect to reimburse  
4080 a hospital for billed hospital fees for covered medical services in the state.

4081 (b) In accordance with Section 68-3-14, the council shall submit a written report to the  
4082 Business and Labor Interim Committee no later than September 1, 2019, 2020, and 2021. Each  
4083 written report shall include:

4084 (i) recommendations on how to reduce hospital costs for purposes of medical benefits  
4085 for workers' compensation;

4086 (ii) aggregate data on hospital billing and payment trends in the state;

4087 (iii) the results of the council's study of hospital fee schedules from other states; and  
4088 (iv) the approximate rate at which a workers' compensation insurance carrier or  
4089 self-insured employer should expect to reimburse a hospital for billed hospital fees for covered  
4090 medical services, calculated in accordance with Subsection (7)(a)(iv).

4091 (c) For each report described in Subsection (7)(b), the commission may contract with a  
4092 third-party expert to assist with the council's duties described in Subsections (7)(a) and (b).

4093 (8) The commissioner or the commissioner's designee shall serve as the chair of the  
4094 council and call the necessary meetings.

4095 (9) The commission shall provide staff support to the council.

4096 (10) A member may not receive compensation or benefits for the member's service, but  
4097 may receive per diem and travel expenses in accordance with:

4098 (a) Section 63A-3-106;

4099 (b) Section 63A-3-107; and

4100 (c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and  
4101 63A-3-107.

4102 Section 46. Section 34A-2-705 is amended to read:

4103 **34A-2-705. Industrial Accident Restricted Account.**

4104 (1) As used in this section:

4105 (a) "Account" means the Industrial Accident Restricted Account created by this  
4106 section.

4107 (b) "Advisory council" means the state workers' compensation advisory council created  
4108 under Section 34A-2-107.

4109 (2) There is created in the General Fund a restricted account known as the "Industrial  
4110 Accident Restricted Account."

4111 (3) (a) The account is funded from:

4112 (i) .5% of the premium income remitted to the state treasurer and credited to the  
4113 account pursuant to Subsection 59-9-101(2)(c)(iv); and

4114 (ii) amounts deposited under Section 34A-2-1003.

4115 (b) If the balance in the account exceeds \$500,000 at the close of a fiscal year, the  
4116 excess shall be transferred to the Uninsured Employers' Fund created under Section 34A-2-704.

4117 (4) (a) From money appropriated by the Legislature from the account to the

- 4118 commission and subject to the requirements of this section, the commission may fund:
- 4119 (i) the activities of the Division of Industrial Accidents described in Section
- 4120 [34A-1-202](#);
- 4121 (ii) the activities of the Division of Adjudication described in Section [34A-1-202](#);
- 4122 [~~and~~]
- 4123 (iii) the activities of the commission described in Section [34A-2-1005](#)~~[:]~~; and
- 4124 (iv) the activities of the commission described in Subsection [34A-2-107\(7\)\(c\)](#), up to
- 4125 \$50,000 for each of the three reports described in Subsection [34A-2-107\(7\)\(b\)](#).
- 4126 (b) The money deposited in the account may not be used for a purpose other than a
- 4127 purpose described in this Subsection (4), including an administrative cost or another activity of
- 4128 the commission unrelated to the account.
- 4129 (5) (a) Each year before the public hearing required by Subsection [59-9-101\(2\)\(d\)\(i\)](#),
- 4130 the commission shall report to the advisory council regarding:
- 4131 (i) the commission's budget request to the governor for the next fiscal year related to:
- 4132 (A) the Division of Industrial Accidents; and
- 4133 (B) the Division of Adjudication;
- 4134 (ii) the expenditures of the commission for the fiscal year in which the commission is
- 4135 reporting related to:
- 4136 (A) the Division of Industrial Accidents; and
- 4137 (B) the Division of Adjudication;
- 4138 (iii) revenues generated from the premium assessment under Section [59-9-101](#) on an
- 4139 admitted insurer writing workers' compensation insurance in this state and on a self-insured
- 4140 employer under Section [34A-2-202](#); and
- 4141 (iv) money deposited under Section [34A-2-1003](#).
- 4142 (b) The commission shall annually report to the governor and the Legislature
- 4143 regarding:
- 4144 (i) the use of the money appropriated to the commission under this section;
- 4145 (ii) revenues generated from the premium assessment under Section [59-9-101](#) on an
- 4146 admitted insurer writing workers' compensation insurance in this state and on a self-insured
- 4147 employer under Section [34A-2-202](#); and
- 4148 (iii) money deposited under Section [34A-2-1003](#).

4149 Section 47. Section **63A-5-205** is amended to read:

4150 **63A-5-205. Contracting powers of director -- Retainage.**

4151 ~~[(1) As used in this section:]~~

4152 ~~[(a) "Capital developments" means the same as that term is defined in Section~~  
4153 ~~63A-5-104.]~~

4154 ~~[(b) "Capital improvements" means the same as that term is defined in Section~~  
4155 ~~63A-5-104.]~~

4156 ~~[(c) "Employee" means an "employee," "worker," or "operative" as defined in Section~~  
4157 ~~34A-2-104 who:]~~

4158 ~~[(i) works at least 30 hours per calendar week; and]~~

4159 ~~[(ii) meets employer eligibility waiting requirements for health care insurance which~~  
4160 ~~may not exceed the first day of the calendar month following 60 days from the date of hire.]~~

4161 ~~[(d) "Health benefit plan" means the same as that term is defined in Section~~  
4162 ~~31A-1-301.]~~

4163 ~~[(e) "Qualified health insurance coverage" means the same as that term is defined in~~  
4164 ~~Section 26-40-115.]~~

4165 ~~[(f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.]~~

4166 ~~[(2)] (1)~~ In accordance with Title 63G, Chapter 6a, Utah Procurement Code, the  
4167 director may:

4168 (a) subject to ~~[Subsections (3) and (4)]~~ Section 63A-5-205.5, enter into ~~[contracts]~~ a  
4169 contract for any work or professional services ~~[which]~~ that the division or the State Building  
4170 Board may do or have done; and

4171 (b) as a condition of any contract for architectural or engineering services, prohibit the  
4172 architect or engineer from retaining a sales or agent engineer for the necessary design work.

4173 ~~[(3) Except as provided in Subsection (4), this Subsection (3) applies to]~~

4174 ~~[all design or construction contracts entered into by the division or the State Building~~  
4175 ~~Board on or after July 1, 2009, and:]~~

4176 ~~[(a) applies to a prime contractor if the prime contract is in the amount of \$2,000,000~~  
4177 ~~or greater at the original execution of the contract; and]~~

4178 ~~[(b) applies to a subcontractor if the subcontract is in the amount of \$1,000,000 or~~  
4179 ~~greater at the original execution of the contract.]~~

4180 ~~[(4) Subsection (3) does not apply:]~~

4181 ~~[(a) if the application of Subsection (3) jeopardizes the receipt of federal funds;]~~

4182 ~~[(b) if the contract is a sole source contract;]~~

4183 ~~[(c) if the contract is an emergency procurement; or]~~

4184 ~~[(d) to a change order as defined in Section 63G-6a-103, or a modification to a~~

4185 ~~contract, when the contract does not meet the threshold required by Subsection (3).]~~

4186 ~~[(5) A person who intentionally uses change orders or contract modifications to~~

4187 ~~circumvent the requirements of Subsection (3) is guilty of an infraction.]~~

4188 ~~[(6) (a) A contractor subject to Subsection (3) shall demonstrate to the director that the~~

4189 ~~contractor has and will maintain an offer of qualified health insurance coverage for the~~

4190 ~~contractor's employees and the employees' dependents.]~~

4191 ~~[(b) If a subcontractor of the contractor is subject to Subsection (3), the contractor~~

4192 ~~shall:]~~

4193 ~~[(i) place a requirement in the subcontract that the subcontractor shall obtain and~~

4194 ~~maintain an offer of qualified health insurance coverage for the subcontractor's employees and~~

4195 ~~the employees' dependants during the duration of the subcontract; and]~~

4196 ~~[(ii) certify to the director that the subcontractor has and will maintain an offer of~~

4197 ~~qualified health insurance coverage for the subcontractor's employees and the employees'~~

4198 ~~dependents during the duration of the prime contract.]~~

4199 ~~[(c) (i) A contractor who fails to meet the requirements of Subsection (6)(a) during the~~

4200 ~~duration of the contract is subject to penalties in accordance with administrative rules adopted~~

4201 ~~by the division under Subsection (7).]~~

4202 ~~[(ii) A contractor is not subject to penalties for the failure of a subcontractor to meet~~

4203 ~~the requirements of Subsection (6)(b).]~~

4204 ~~[(iii) A subcontractor who fails to meet the requirements of Subsection (6)(b) during~~

4205 ~~the duration of the contract is subject to penalties in accordance with administrative rules~~

4206 ~~adopted by the division under Subsection (7).]~~

4207 ~~[(iv) A subcontractor is not subject to penalties for the failure of a contractor to meet~~

4208 ~~the requirements of Subsection (6)(a).]~~

4209 ~~[(7) The division shall adopt administrative rules:]~~

4210 ~~[(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;]~~

4211 ~~[(b) in coordination with:]~~  
4212 ~~[(i) the Department of Environmental Quality in accordance with Section 19-1-206;]~~  
4213 ~~[(ii) the Department of Natural Resources in accordance with Section 79-2-404;]~~  
4214 ~~[(iii) a public transit district in accordance with Section 17B-2a-818.5;]~~  
4215 ~~[(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;]~~  
4216 ~~[(v) the Department of Transportation in accordance with Section 72-6-107.5; and]~~  
4217 ~~[(vi) the Legislature's Administrative Rules Review Committee; and]~~  
4218 ~~[(c) that establish:]~~  
4219 ~~[(i) the requirements and procedures a contractor must follow to demonstrate to the~~  
4220 ~~director compliance with Subsections (3) through (10) that shall include:]~~  
4221 ~~[(A) that a contractor shall demonstrate compliance with Subsection (6)(a) or (b) at the~~  
4222 ~~time of the execution of each initial contract described in Subsection (3);]~~  
4223 ~~[(B) that the contractor's compliance is subject to an audit by the division or the Office~~  
4224 ~~of the Legislative Auditor General; and]~~  
4225 ~~[(C) that the actuarially equivalent determination required for the qualified health~~  
4226 ~~insurance coverage in Subsection (1) is met by the contractor if the contractor provides the~~  
4227 ~~department or division with a written statement of actuarial equivalency, which is not more~~  
4228 ~~than one year old, regarding the contractor's offer of qualified health coverage from an actuary~~  
4229 ~~selected by the contractor or the contractor's insurer, or an underwriter who is responsible for~~  
4230 ~~developing the employer group's premium rates;]~~  
4231 ~~[(ii) the penalties that may be imposed if a contractor or subcontractor intentionally~~  
4232 ~~violates the provisions of Subsections (3) through (10), which may include:]~~  
4233 ~~[(A) a three-month suspension of the contractor or subcontractor from entering into~~  
4234 ~~future contracts with the state upon the first violation;]~~  
4235 ~~[(B) a six-month suspension of the contractor or subcontractor from entering into~~  
4236 ~~future contracts with the state upon the second violation;]~~  
4237 ~~[(C) an action for debarment of the contractor or subcontractor in accordance with~~  
4238 ~~Section 63G-6a-904 upon the third or subsequent violation; and]~~  
4239 ~~[(D) monetary penalties which may not exceed 50% of the amount necessary to~~  
4240 ~~purchase qualified health insurance coverage for an employee and the dependents of an~~  
4241 ~~employee of the contractor or subcontractor who was not offered qualified health insurance~~

4242 ~~coverage during the duration of the contract; and]~~

4243 ~~[(iii) a website on which the department shall post the commercially equivalent~~  
4244 ~~benchmark, for the qualified health insurance coverage identified in Subsection (1)(c), that is~~  
4245 ~~provided by the Department of Health, in accordance with Subsection ~~26-40-115~~(2).]~~

4246 ~~[(8)(a) In addition to the penalties imposed under Subsection (7)(c), a contractor or~~  
4247 ~~subcontractor who intentionally violates the provisions of this section shall be liable to the~~  
4248 ~~employee for health care costs that would have been covered by qualified health insurance~~  
4249 ~~coverage.]~~

4250 ~~[(b) An employer has an affirmative defense to a cause of action under Subsection~~  
4251 ~~(8)(a) if:]~~

4252 ~~[(i) the employer relied in good faith on a written statement of actuarial equivalency~~  
4253 ~~provided by:]~~

4254 ~~[(A) an actuary; or]~~

4255 ~~[(B) an underwriter who is responsible for developing the employer group's premium~~  
4256 ~~rates; or]~~

4257 ~~[(ii) the department determines that compliance with this section is not required under~~  
4258 ~~the provisions of Subsection (4).]~~

4259 ~~[(c) An employee has a private right of action only against the employee's employer to~~  
4260 ~~enforce the provisions of this Subsection (8).]~~

4261 ~~[(9) Any penalties imposed and collected under this section shall be deposited into the~~  
4262 ~~Medicaid Restricted Account created by Section ~~26-18-402~~.]~~

4263 ~~[(10) The failure of a contractor or subcontractor to provide qualified health insurance~~  
4264 ~~coverage as required by this section:]~~

4265 ~~[(a) may not be the basis for a protest or other action from a prospective bidder,~~  
4266 ~~offeror, or contractor under Section ~~63G-6a-1602~~ or any other provision in Title 63G, Chapter~~  
4267 ~~6a, Utah Procurement Code; and]~~

4268 ~~[(b) may not be used by the procurement entity or a prospective bidder, offeror, or~~  
4269 ~~contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design~~  
4270 ~~or construction.]~~

4271 ~~[(H)]~~ (2) The judgment of the director as to the responsibility and qualifications of a  
4272 bidder is conclusive, except in case of fraud or bad faith.

4273 ~~[(12)]~~ (3) The division shall make all payments to the contractor for completed work in  
4274 accordance with the contract and pay the interest specified in the contract on any payments that  
4275 are late.

4276 ~~[(13)]~~ (4) If any payment on a contract with a private contractor to do work for the  
4277 division or the State Building Board is retained or withheld, it shall be retained or withheld and  
4278 released as provided in Section [13-8-5](#).

4279 Section 48. Section **63A-5-205.5** is enacted to read:

4280 **63A-5-205.5. Health insurance requirements -- Penalties.**

4281 (1) As used in this section:

4282 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
4283 related to a single project.

4284 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

4285 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
4286 "operative" who:

4287 (i) works at least 30 hours per calendar week; and

4288 (ii) meets employer eligibility waiting requirements for health care insurance, which  
4289 may not exceed the first day of the calendar month following 60 days after the day on which  
4290 the individual is hired.

4291 (d) "Health benefit plan" means the same as that term is defined in Section [31A-1-301](#).

4292 (e) "Qualified health insurance coverage" means the same as that term is defined in  
4293 Section [26-40-115](#).

4294 (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).

4295 (2) Except as provided in Subsection (3), the requirements of this section apply to:

4296 (a) a contractor of a design or construction contract entered into by the division or the  
4297 State Building Board on or after July 1, 2009, if the prime contract is in an aggregate amount  
4298 equal to or greater than \$2,000,000; and

4299 (b) a subcontractor of a contractor of a design or construction contract entered into by  
4300 the division or State Building Board on or after July 1, 2009, if the subcontract is in an  
4301 aggregate amount equal to or greater than \$1,000,000.

4302 (3) The requirements of this section do not apply to a contractor or subcontractor  
4303 described in Subsection (2) if:

- 4304 (a) the application of this section jeopardizes the receipt of federal funds;  
4305 (b) the contract is a sole source contract; or  
4306 (c) the contract is an emergency procurement.  
4307 (4) A person that intentionally uses change orders, contract modifications, or multiple  
4308 contracts to circumvent the requirements of this section is guilty of an infraction.  
4309 (5) (a) A contractor that is subject to the requirements of this section shall demonstrate  
4310 to the director that the contractor has and will maintain an offer of qualified health insurance  
4311 coverage for the contractor's employees and the employees' dependents by submitting to the  
4312 director a written statement that:  
4313 (i) certifies that the contractor offers qualified health insurance coverage in accordance  
4314 with Section [26-40-115](#);  
4315 (ii) is from:  
4316 (A) an actuary selected by the contractor or the contractor's insurer; or  
4317 (B) an underwriter who is responsible for developing the employer group's premium  
4318 rates; and  
4319 (iii) was created within one year before the day on which the statement is submitted.  
4320 (b) A contractor that is subject to the requirements of this section shall:  
4321 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that  
4322 is subject to the requirements of this section shall obtain and maintain an offer of qualified  
4323 health insurance coverage for the subcontractor's employees and the employees' dependents  
4324 during the duration of the subcontract; and  
4325 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
4326 written statement that:  
4327 (A) certifies that the subcontractor offers qualified health insurance coverage in  
4328 accordance with Section [26-40-115](#);  
4329 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an  
4330 underwriter who is responsible for developing the employer group's premium rates; and  
4331 (C) was created within one year before the day on which the contractor obtains the  
4332 statement.  
4333 (c) (i) (A) A contractor that fails to maintain an offer of qualified health insurance  
4334 coverage described in Subsection (5)(a) during the duration of the contract is subject to

4335 penalties in accordance with administrative rules adopted by the division under Subsection (6).

4336 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
4337 and maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i).

4338 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
4339 insurance coverage described in Subsection (5)(b)(i) during the duration of the subcontract is  
4340 subject to penalties in accordance with administrative rules adopted by the division under  
4341 Subsection (6).

4342 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
4343 an offer of qualified health insurance coverage described in Subsection (5)(a).

4344 (6) The division shall adopt administrative rules:

4345 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

4346 (b) in coordination with:

4347 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

4348 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

4349 (iii) a public transit district in accordance with Section [17B-2a-818.5](#);

4350 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);

4351 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and

4352 (vi) the Legislature's Administrative Rules Review Committee; and

4353 (c) that establish:

4354 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
4355 demonstrate compliance with this section, including:

4356 (A) that a contractor or subcontractor's compliance with this section is subject to an  
4357 audit by the division or the Office of the Legislative Auditor General;

4358 (B) that a contractor that is subject to the requirements of this section shall obtain a  
4359 written statement described in Subsection (5)(a); and

4360 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
4361 written statement described in Subsection (5)(b)(ii);

4362 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
4363 violates the provisions of this section, which may include:

4364 (A) a three-month suspension of the contractor or subcontractor from entering into  
4365 future contracts with the state upon the first violation;

4366 (B) a six-month suspension of the contractor or subcontractor from entering into future  
4367 contracts with the state upon the second violation;

4368 (C) an action for debarment of the contractor or subcontractor in accordance with  
4369 Section [63G-6a-904](#) upon the third or subsequent violation; and

4370 (D) monetary penalties which may not exceed 50% of the amount necessary to  
4371 purchase qualified health insurance coverage for employees and dependents of employees of  
4372 the contractor or subcontractor who were not offered qualified health insurance coverage  
4373 during the duration of the contract; and

4374 (iii) a website on which the department shall post the commercially equivalent  
4375 benchmark for the qualified health insurance coverage that is provided by the Department of  
4376 Health in accordance with Subsection [26-40-115\(2\)](#).

4377 (7) (a) During the duration of a contract, the division may perform an audit to verify a  
4378 contractor or subcontractor's compliance with this section.

4379 (b) Upon the division's request, a contractor or subcontractor shall provide the division:

4380 (i) a signed actuarial certification that the coverage the contractor or subcontractor  
4381 offers is qualified health insurance coverage; or

4382 (ii) all relevant documents and information necessary for the division to determine  
4383 compliance with this section.

4384 (c) If a contractor or subcontractor provides the documents and information described  
4385 in Subsection (7)(b)(ii), the Insurance Department shall assist the division in determining if the  
4386 coverage the contractor or subcontractor offers is qualified health insurance coverage.

4387 (8) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
4388 or subcontractor that intentionally violates the provisions of this section is liable to the  
4389 employee for health care costs that would have been covered by qualified health insurance  
4390 coverage.

4391 (ii) An employer has an affirmative defense to a cause of action under Subsection  
4392 (8)(a) if:

4393 (A) the employer relied in good faith on a written statement described in Subsection  
4394 (5)(a) or (5)(b)(ii); or

4395 (B) the department determines that compliance with this section is not required under  
4396 the provisions of Subsection (3).

4397 (b) An employee has a private right of action only against the employee's employer to  
4398 enforce the provisions of this Subsection (8).

4399 (9) Any penalties imposed and collected under this section shall be deposited into the  
4400 Medicaid Restricted Account created by Section [26-18-402](#).

4401 (10) The failure of a contractor or subcontractor to provide qualified health insurance  
4402 coverage as required by this section:

4403 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
4404 or contractor under:

4405 (i) Section [63G-6a-1602](#); or

4406 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

4407 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
4408 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
4409 or construction.

4410 Section 49. Section **63C-9-403** is amended to read:

4411 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**

4412 (1) ~~[For purposes of]~~ As used in this section:

4413 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
4414 related to a single project.

4415 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

4416 ~~[(a)]~~ (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee,"

4417 "worker," or "operative" ~~[as defined in Section [34A-2-104](#)]~~ who:

4418 (i) works at least 30 hours per calendar week; and

4419 (ii) meets employer eligibility waiting requirements for health care insurance, which  
4420 may not exceed the first of the calendar month following 60 days ~~[from the date of hire]~~ after  
4421 the day on which the individual is hired.

4422 ~~[(b)]~~ (d) "Health benefit plan" means the same as that term is defined in Section  
4423 [31A-1-301](#).

4424 ~~[(c)]~~ (e) "Qualified health insurance coverage" means the same as that term is defined  
4425 in Section [26-40-115](#).

4426 ~~[(d)]~~ (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).

4427 ~~[(2) (a) Except as provided in Subsection (3), this section applies to a design or~~

4428 ~~construction contract entered into by the board or on behalf of the board on or after July 1,~~  
 4429 ~~2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).]~~

4430 ~~[(b) (i) A prime contractor is subject to this section if the prime contract is in the~~  
 4431 ~~amount of \$2,000,000 or greater at the original execution of the contract.]~~

4432 ~~[(ii) A subcontractor is subject to this section if a subcontract is in the amount of~~  
 4433 ~~\$1,000,000 or greater at the original execution of the contract.]~~

4434 ~~[(3) This section does not apply if:]~~

4435 (2) Except as provided in Subsection (3), the requirements of this section apply to:

4436 (a) a contractor of a design or construction contract entered into by the board, or on  
 4437 behalf of the board, on or after July 1, 2009, if the prime contract is in an aggregate amount  
 4438 equal to or greater than \$2,000,000; and

4439 (b) a subcontractor of a contractor of a design or construction contract entered into by  
 4440 the board, or on behalf of the board, on or after July 1, 2009, if the subcontract is in an  
 4441 aggregate amount equal to or greater than \$1,000,000.

4442 (3) The requirements of this section do not apply to a contractor or subcontractor  
 4443 described in Subsection (2) if:

4444 (a) the application of this section jeopardizes the receipt of federal funds;

4445 (b) the contract is a sole source contract; or

4446 (c) the contract is an emergency procurement.

4447 ~~[(4) (a) This section does not apply to a change order as defined in Section~~

4448 ~~63G-6a-103, or a modification to a contract, when the contract does not meet the initial~~  
 4449 ~~threshold required by Subsection (2).]~~

4450 ~~[(b)]~~ (4) A person [who] that intentionally uses change orders [or], contract  
 4451 modifications, or multiple contracts to circumvent the requirements of [Subsection (2)] this  
 4452 section is guilty of an infraction.

4453 (5) (a) A contractor subject to [Subsection (2)] the requirements of this section shall  
 4454 demonstrate to the executive director that the contractor has and will maintain an offer of  
 4455 qualified health insurance coverage for the contractor's employees and the employees'  
 4456 dependents during the duration of the contract[:]. by submitting to the executive director a  
 4457 written statement that:

4458 ~~[(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor~~

4459 shall:]

4460 (i) certifies that the contractor offers qualified health insurance coverage in accordance  
4461 with Section 26-40-115;

4462 (ii) is from:

4463 (A) an actuary selected by the contractor or the contractor's insurer; or

4464 (B) an underwriter who is responsible for developing the employer group's premium  
4465 rates; and

4466 (iii) was created within one year before the day on which the statement is submitted.

4467 (b) A contractor that is subject to the requirements of this section shall:

4468 (i) place a requirement in [the subcontract that the subcontractor] each of the  
4469 contractor's subcontracts that a subcontractor that is subject to the requirements of this section  
4470 shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's  
4471 employees and the employees' dependents during the duration of the subcontract; and

4472 ~~[(ii) certify to the executive director that the subcontractor has and will maintain an~~  
4473 ~~offer of qualified health insurance coverage for the subcontractor's employees and the~~  
4474 ~~employees' dependents during the duration of the prime contract.]~~

4475 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
4476 written statement that:

4477 (A) certifies that the subcontractor offers qualified health insurance coverage in  
4478 accordance with Section 26-40-115;

4479 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an  
4480 underwriter who is responsible for developing the employer group's premium rates; and

4481 (C) was created within one year before the day on which the contractor obtains the  
4482 statement.

4483 (c) (i) (A) A contractor [who fails to meet the requirements of] that fails to maintain an  
4484 offer of qualified health insurance coverage as described in Subsection (5)(a) during the  
4485 duration of the contract is subject to penalties in accordance with administrative rules adopted  
4486 by the division under Subsection (6).

4487 (B) A contractor is not subject to penalties for the failure of a subcontractor to [meet  
4488 the requirements of] obtain and maintain an offer of qualified health insurance coverage  
4489 described in Subsection (5)(b)(i).

4490 (ii) (A) A subcontractor [~~who fails to meet the requirements of~~] that fails to obtain and  
 4491 maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i)  
 4492 during the duration of the [~~contract~~] subcontract is subject to penalties in accordance with  
 4493 administrative rules adopted by the department under Subsection (6).

4494 (B) A subcontractor is not subject to penalties for the failure of a contractor to [~~meet~~  
 4495 ~~the requirements of~~] maintain an offer of qualified health insurance coverage described in  
 4496 Subsection (5)(a).

4497 (6) The department shall adopt administrative rules:

4498 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

4499 (b) in coordination with:

4500 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

4501 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

4502 (iii) the State Building Board in accordance with Section [~~63A-5-205~~] [63A-5-205.5](#);

4503 (iv) a public transit district in accordance with Section [17B-2a-818.5](#);

4504 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and

4505 (vi) the Legislature's Administrative Rules Review Committee; and

4506 (c) that establish:

4507 (i) the requirements and procedures a contractor [~~must~~] and a subcontractor shall  
 4508 follow to demonstrate [~~to the executive director~~] compliance with this section [~~that shall~~  
 4509 ~~include~~], including:

4510 [~~(A) that a contractor shall demonstrate compliance with Subsection (5)(a) or (b) at the~~  
 4511 ~~time of the execution of each initial contract described in Subsection (2)(b);]~~

4512 [~~(B) that the contractor's]~~

4513 (A) that a contractor or subcontractor's compliance with this section is subject to an  
 4514 audit by the department or the Office of the Legislative Auditor General; [~~and]~~

4515 [~~(C) that the actuarially equivalent determination required for the qualified health~~  
 4516 ~~insurance coverage in Subsection (1) is met by the contractor if the contractor provides the~~  
 4517 ~~department or division with a written statement of actuarial equivalency, which is no more than~~  
 4518 ~~one year old, regarding the contractor's offer of qualified health coverage from an actuary~~  
 4519 ~~selected by the contractor or the contractor's insurer, or an underwriter who is responsible for~~  
 4520 ~~developing the employer group's premium rates;]~~

4521 (B) that a contractor that is subject to the requirements of this section shall obtain a  
4522 written statement described in Subsection (5)(a); and

4523 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
4524 written statement described in Subsection (5)(b)(ii);

4525 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
4526 violates the provisions of this section, which may include:

4527 (A) a three-month suspension of the contractor or subcontractor from entering into  
4528 future contracts with the state upon the first violation;

4529 (B) a six-month suspension of the contractor or subcontractor from entering into future  
4530 contracts with the state upon the second violation;

4531 (C) an action for debarment of the contractor or subcontractor in accordance with  
4532 Section [63G-6a-904](#) upon the third or subsequent violation; and

4533 (D) monetary penalties which may not exceed 50% of the amount necessary to  
4534 purchase qualified health insurance coverage for employees and dependents of employees of  
4535 the contractor or subcontractor who were not offered qualified health insurance coverage  
4536 during the duration of the contract; and

4537 (iii) a website on which the department shall post the commercially equivalent  
4538 benchmark, for the qualified health insurance coverage identified in Subsection (1)~~(f)~~(e), that  
4539 is provided by the Department of Health, in accordance with Subsection [26-40-115\(2\)](#).

4540 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
4541 or subcontractor who intentionally violates the provisions of this section ~~shall be~~ is liable to  
4542 the employee for health care costs that would have been covered by qualified health insurance  
4543 coverage.

4544 (ii) An employer has an affirmative defense to a cause of action under Subsection  
4545 (7)(a)(i) if:

4546 (A) the employer relied in good faith on a written statement ~~[of actuarial equivalency~~  
4547 ~~provided by:]~~ described in Subsection (5)(a) or (5)(b)(ii); or

4548 ~~[(f) an actuary; or]~~

4549 ~~[(H) an underwriter who is responsible for developing the employer group's premium~~  
4550 ~~rates; or]~~

4551 (B) the department determines that compliance with this section is not required under

4552 the provisions of Subsection (3) [~~or (4)~~].

4553 (b) An employee has a private right of action only against the employee's employer to  
4554 enforce the provisions of this Subsection (7).

4555 (8) Any penalties imposed and collected under this section shall be deposited into the  
4556 Medicaid Restricted Account created in Section [26-18-402](#).

4557 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
4558 coverage as required by this section:

4559 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
4560 or contractor under:

4561 (i) Section [63G-6a-1602](#); or

4562 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

4563 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
4564 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
4565 or construction.

4566 Section 50. Section **63G-2-305** is amended to read:

4567 **63G-2-305. Protected records.**

4568 The following records are protected if properly classified by a governmental entity:

4569 (1) trade secrets as defined in Section [13-24-2](#) if the person submitting the trade secret  
4570 has provided the governmental entity with the information specified in Section [63G-2-309](#);

4571 (2) commercial information or nonindividual financial information obtained from a  
4572 person if:

4573 (a) disclosure of the information could reasonably be expected to result in unfair  
4574 competitive injury to the person submitting the information or would impair the ability of the  
4575 governmental entity to obtain necessary information in the future;

4576 (b) the person submitting the information has a greater interest in prohibiting access  
4577 than the public in obtaining access; and

4578 (c) the person submitting the information has provided the governmental entity with  
4579 the information specified in Section [63G-2-309](#);

4580 (3) commercial or financial information acquired or prepared by a governmental entity  
4581 to the extent that disclosure would lead to financial speculations in currencies, securities, or  
4582 commodities that will interfere with a planned transaction by the governmental entity or cause

4583 substantial financial injury to the governmental entity or state economy;

4584 (4) records, the disclosure of which could cause commercial injury to, or confer a  
4585 competitive advantage upon a potential or actual competitor of, a commercial project entity as  
4586 defined in Subsection 11-13-103(4);

4587 (5) test questions and answers to be used in future license, certification, registration,  
4588 employment, or academic examinations;

4589 (6) records, the disclosure of which would impair governmental procurement  
4590 proceedings or give an unfair advantage to any person proposing to enter into a contract or  
4591 agreement with a governmental entity, except, subject to Subsections (1) and (2), that this  
4592 Subsection (6) does not restrict the right of a person to have access to, after the contract or  
4593 grant has been awarded and signed by all parties, a bid, proposal, application, or other  
4594 information submitted to or by a governmental entity in response to:

4595 (a) an invitation for bids;

4596 (b) a request for proposals;

4597 (c) a request for quotes;

4598 (d) a grant; or

4599 (e) other similar document;

4600 (7) information submitted to or by a governmental entity in response to a request for  
4601 information, except, subject to Subsections (1) and (2), that this Subsection (7) does not restrict  
4602 the right of a person to have access to the information, after:

4603 (a) a contract directly relating to the subject of the request for information has been  
4604 awarded and signed by all parties; or

4605 (b) (i) a final determination is made not to enter into a contract that relates to the  
4606 subject of the request for information; and

4607 (ii) at least two years have passed after the day on which the request for information is  
4608 issued;

4609 (8) records that would identify real property or the appraisal or estimated value of real  
4610 or personal property, including intellectual property, under consideration for public acquisition  
4611 before any rights to the property are acquired unless:

4612 (a) public interest in obtaining access to the information is greater than or equal to the  
4613 governmental entity's need to acquire the property on the best terms possible;

4614 (b) the information has already been disclosed to persons not employed by or under a  
4615 duty of confidentiality to the entity;

4616 (c) in the case of records that would identify property, potential sellers of the described  
4617 property have already learned of the governmental entity's plans to acquire the property;

4618 (d) in the case of records that would identify the appraisal or estimated value of  
4619 property, the potential sellers have already learned of the governmental entity's estimated value  
4620 of the property; or

4621 (e) the property under consideration for public acquisition is a single family residence  
4622 and the governmental entity seeking to acquire the property has initiated negotiations to acquire  
4623 the property as required under Section 78B-6-505;

4624 (9) records prepared in contemplation of sale, exchange, lease, rental, or other  
4625 compensated transaction of real or personal property including intellectual property, which, if  
4626 disclosed prior to completion of the transaction, would reveal the appraisal or estimated value  
4627 of the subject property, unless:

4628 (a) the public interest in access is greater than or equal to the interests in restricting  
4629 access, including the governmental entity's interest in maximizing the financial benefit of the  
4630 transaction; or

4631 (b) when prepared by or on behalf of a governmental entity, appraisals or estimates of  
4632 the value of the subject property have already been disclosed to persons not employed by or  
4633 under a duty of confidentiality to the entity;

4634 (10) records created or maintained for civil, criminal, or administrative enforcement  
4635 purposes or audit purposes, or for discipline, licensing, certification, or registration purposes, if  
4636 release of the records:

4637 (a) reasonably could be expected to interfere with investigations undertaken for  
4638 enforcement, discipline, licensing, certification, or registration purposes;

4639 (b) reasonably could be expected to interfere with audits, disciplinary, or enforcement  
4640 proceedings;

4641 (c) would create a danger of depriving a person of a right to a fair trial or impartial  
4642 hearing;

4643 (d) reasonably could be expected to disclose the identity of a source who is not  
4644 generally known outside of government and, in the case of a record compiled in the course of

4645 an investigation, disclose information furnished by a source not generally known outside of  
4646 government if disclosure would compromise the source; or

4647 (e) reasonably could be expected to disclose investigative or audit techniques,  
4648 procedures, policies, or orders not generally known outside of government if disclosure would  
4649 interfere with enforcement or audit efforts;

4650 (11) records the disclosure of which would jeopardize the life or safety of an  
4651 individual;

4652 (12) records the disclosure of which would jeopardize the security of governmental  
4653 property, governmental programs, or governmental recordkeeping systems from damage, theft,  
4654 or other appropriation or use contrary to law or public policy;

4655 (13) records that, if disclosed, would jeopardize the security or safety of a correctional  
4656 facility, or records relating to incarceration, treatment, probation, or parole, that would interfere  
4657 with the control and supervision of an offender's incarceration, treatment, probation, or parole;

4658 (14) records that, if disclosed, would reveal recommendations made to the Board of  
4659 Pardons and Parole by an employee of or contractor for the Department of Corrections, the  
4660 Board of Pardons and Parole, or the Department of Human Services that are based on the  
4661 employee's or contractor's supervision, diagnosis, or treatment of any person within the board's  
4662 jurisdiction;

4663 (15) records and audit workpapers that identify audit, collection, and operational  
4664 procedures and methods used by the State Tax Commission, if disclosure would interfere with  
4665 audits or collections;

4666 (16) records of a governmental audit agency relating to an ongoing or planned audit  
4667 until the final audit is released;

4668 (17) records that are subject to the attorney client privilege;

4669 (18) records prepared for or by an attorney, consultant, surety, indemnitor, insurer,  
4670 employee, or agent of a governmental entity for, or in anticipation of, litigation or a judicial,  
4671 quasi-judicial, or administrative proceeding;

4672 (19) (a) (i) personal files of a state legislator, including personal correspondence to or  
4673 from a member of the Legislature; and

4674 (ii) notwithstanding Subsection (19)(a)(i), correspondence that gives notice of  
4675 legislative action or policy may not be classified as protected under this section; and

4676 (b) (i) an internal communication that is part of the deliberative process in connection  
4677 with the preparation of legislation between:

4678 (A) members of a legislative body;

4679 (B) a member of a legislative body and a member of the legislative body's staff; or

4680 (C) members of a legislative body's staff; and

4681 (ii) notwithstanding Subsection (19)(b)(i), a communication that gives notice of  
4682 legislative action or policy may not be classified as protected under this section;

4683 (20) (a) records in the custody or control of the Office of Legislative Research and  
4684 General Counsel, that, if disclosed, would reveal a particular legislator's contemplated  
4685 legislation or contemplated course of action before the legislator has elected to support the  
4686 legislation or course of action, or made the legislation or course of action public; and

4687 (b) notwithstanding Subsection (20)(a), the form to request legislation submitted to the  
4688 Office of Legislative Research and General Counsel is a public document unless a legislator  
4689 asks that the records requesting the legislation be maintained as protected records until such  
4690 time as the legislator elects to make the legislation or course of action public;

4691 (21) research requests from legislators to the Office of Legislative Research and  
4692 General Counsel or the Office of the Legislative Fiscal Analyst and research findings prepared  
4693 in response to these requests;

4694 (22) drafts, unless otherwise classified as public;

4695 (23) records concerning a governmental entity's strategy about:

4696 (a) collective bargaining; or

4697 (b) imminent or pending litigation;

4698 (24) records of investigations of loss occurrences and analyses of loss occurrences that  
4699 may be covered by the Risk Management Fund, the Employers' Reinsurance Fund, the  
4700 Uninsured Employers' Fund, or similar divisions in other governmental entities;

4701 (25) records, other than personnel evaluations, that contain a personal recommendation  
4702 concerning an individual if disclosure would constitute a clearly unwarranted invasion of  
4703 personal privacy, or disclosure is not in the public interest;

4704 (26) records that reveal the location of historic, prehistoric, paleontological, or  
4705 biological resources that if known would jeopardize the security of those resources or of  
4706 valuable historic, scientific, educational, or cultural information;

4707 (27) records of independent state agencies if the disclosure of the records would  
4708 conflict with the fiduciary obligations of the agency;

4709 (28) records of an institution within the state system of higher education defined in  
4710 Section 53B-1-102 regarding tenure evaluations, appointments, applications for admissions,  
4711 retention decisions, and promotions, which could be properly discussed in a meeting closed in  
4712 accordance with Title 52, Chapter 4, Open and Public Meetings Act, provided that records of  
4713 the final decisions about tenure, appointments, retention, promotions, or those students  
4714 admitted, may not be classified as protected under this section;

4715 (29) records of the governor's office, including budget recommendations, legislative  
4716 proposals, and policy statements, that if disclosed would reveal the governor's contemplated  
4717 policies or contemplated courses of action before the governor has implemented or rejected  
4718 those policies or courses of action or made them public;

4719 (30) records of the Office of the Legislative Fiscal Analyst relating to budget analysis,  
4720 revenue estimates, and fiscal notes of proposed legislation before issuance of the final  
4721 recommendations in these areas;

4722 (31) records provided by the United States or by a government entity outside the state  
4723 that are given to the governmental entity with a requirement that they be managed as protected  
4724 records if the providing entity certifies that the record would not be subject to public disclosure  
4725 if retained by it;

4726 (32) transcripts, minutes, or reports of the closed portion of a meeting of a public body  
4727 except as provided in Section 52-4-206;

4728 (33) records that would reveal the contents of settlement negotiations but not including  
4729 final settlements or empirical data to the extent that they are not otherwise exempt from  
4730 disclosure;

4731 (34) memoranda prepared by staff and used in the decision-making process by an  
4732 administrative law judge, a member of the Board of Pardons and Parole, or a member of any  
4733 other body charged by law with performing a quasi-judicial function;

4734 (35) records that would reveal negotiations regarding assistance or incentives offered  
4735 by or requested from a governmental entity for the purpose of encouraging a person to expand  
4736 or locate a business in Utah, but only if disclosure would result in actual economic harm to the  
4737 person or place the governmental entity at a competitive disadvantage, but this section may not

4738 be used to restrict access to a record evidencing a final contract;

4739 (36) materials to which access must be limited for purposes of securing or maintaining  
4740 the governmental entity's proprietary protection of intellectual property rights including patents,  
4741 copyrights, and trade secrets;

4742 (37) the name of a donor or a prospective donor to a governmental entity, including an  
4743 institution within the state system of higher education defined in Section 53B-1-102, and other  
4744 information concerning the donation that could reasonably be expected to reveal the identity of  
4745 the donor, provided that:

4746 (a) the donor requests anonymity in writing;

4747 (b) any terms, conditions, restrictions, or privileges relating to the donation may not be  
4748 classified protected by the governmental entity under this Subsection (37); and

4749 (c) except for an institution within the state system of higher education defined in  
4750 Section 53B-1-102, the governmental unit to which the donation is made is primarily engaged  
4751 in educational, charitable, or artistic endeavors, and has no regulatory or legislative authority  
4752 over the donor, a member of the donor's immediate family, or any entity owned or controlled  
4753 by the donor or the donor's immediate family;

4754 (38) accident reports, except as provided in Sections 41-6a-404, 41-12a-202, and  
4755 73-18-13;

4756 (39) a notification of workers' compensation insurance coverage described in Section  
4757 34A-2-205;

4758 (40) (a) the following records of an institution within the state system of higher  
4759 education defined in Section 53B-1-102, which have been developed, discovered, disclosed to,  
4760 or received by or on behalf of faculty, staff, employees, or students of the institution:

4761 (i) unpublished lecture notes;

4762 (ii) unpublished notes, data, and information:

4763 (A) relating to research; and

4764 (B) of:

4765 (I) the institution within the state system of higher education defined in Section  
4766 53B-1-102; or

4767 (II) a sponsor of sponsored research;

4768 (iii) unpublished manuscripts;

- 4769 (iv) creative works in process;
- 4770 (v) scholarly correspondence; and
- 4771 (vi) confidential information contained in research proposals;
- 4772 (b) Subsection (40)(a) may not be construed to prohibit disclosure of public
- 4773 information required pursuant to Subsection [53B-16-302\(2\)\(a\)](#) or (b); and
- 4774 (c) Subsection (40)(a) may not be construed to affect the ownership of a record;
- 4775 (41) (a) records in the custody or control of the Office of Legislative Auditor General
- 4776 that would reveal the name of a particular legislator who requests a legislative audit prior to the
- 4777 date that audit is completed and made public; and
- 4778 (b) notwithstanding Subsection (41)(a), a request for a legislative audit submitted to the
- 4779 Office of the Legislative Auditor General is a public document unless the legislator asks that
- 4780 the records in the custody or control of the Office of Legislative Auditor General that would
- 4781 reveal the name of a particular legislator who requests a legislative audit be maintained as
- 4782 protected records until the audit is completed and made public;
- 4783 (42) records that provide detail as to the location of an explosive, including a map or
- 4784 other document that indicates the location of:
  - 4785 (a) a production facility; or
  - 4786 (b) a magazine;
- 4787 (43) information:
  - 4788 (a) contained in the statewide database of the Division of Aging and Adult Services
  - 4789 created by Section [62A-3-311.1](#); or
  - 4790 (b) received or maintained in relation to the Identity Theft Reporting Information
  - 4791 System (IRIS) established under Section [67-5-22](#);
- 4792 (44) information contained in the Management Information System and Licensing
- 4793 Information System described in Title 62A, Chapter 4a, Child and Family Services;
- 4794 (45) information regarding National Guard operations or activities in support of the
- 4795 National Guard's federal mission;
- 4796 (46) records provided by any pawn or secondhand business to a law enforcement
- 4797 agency or to the central database in compliance with Title 13, Chapter 32a, Pawnshop and
- 4798 Secondhand Merchandise Transaction Information Act;
- 4799 (47) information regarding food security, risk, and vulnerability assessments performed

4800 by the Department of Agriculture and Food;

4801 (48) except to the extent that the record is exempt from this chapter pursuant to Section  
4802 63G-2-106, records related to an emergency plan or program, a copy of which is provided to or  
4803 prepared or maintained by the Division of Emergency Management, and the disclosure of  
4804 which would jeopardize:

4805 (a) the safety of the general public; or

4806 (b) the security of:

4807 (i) governmental property;

4808 (ii) governmental programs; or

4809 (iii) the property of a private person who provides the Division of Emergency  
4810 Management information;

4811 (49) records of the Department of Agriculture and Food that provides for the  
4812 identification, tracing, or control of livestock diseases, including any program established under  
4813 Title 4, Chapter 24, Utah Livestock Brand and Anti-Theft Act, or Title 4, Chapter 31, Control  
4814 of Animal Disease;

4815 (50) as provided in Section 26-39-501:

4816 (a) information or records held by the Department of Health related to a complaint  
4817 regarding a child care program or residential child care which the department is unable to  
4818 substantiate; and

4819 (b) information or records related to a complaint received by the Department of Health  
4820 from an anonymous complainant regarding a child care program or residential child care;

4821 (51) unless otherwise classified as public under Section 63G-2-301 and except as  
4822 provided under Section 41-1a-116, an individual's home address, home telephone number, or  
4823 personal mobile phone number, if:

4824 (a) the individual is required to provide the information in order to comply with a law,  
4825 ordinance, rule, or order of a government entity; and

4826 (b) the subject of the record has a reasonable expectation that this information will be  
4827 kept confidential due to:

4828 (i) the nature of the law, ordinance, rule, or order; and

4829 (ii) the individual complying with the law, ordinance, rule, or order;

4830 (52) the name, home address, work addresses, and telephone numbers of an individual

4831 that is engaged in, or that provides goods or services for, medical or scientific research that is:

4832 (a) conducted within the state system of higher education, as defined in Section  
4833 [53B-1-102](#); and

4834 (b) conducted using animals;

4835 (53) an initial proposal under Title 63N, Chapter 13, Part 2, Government Procurement  
4836 Private Proposal Program, to the extent not made public by rules made under that chapter;

4837 (54) in accordance with Section [78A-12-203](#), any record of the Judicial Performance  
4838 Evaluation Commission concerning an individual commissioner's vote on whether or not to  
4839 recommend that the voters retain a judge including information disclosed under Subsection  
4840 [78A-12-203\(5\)\(e\)](#);

4841 (55) information collected and a report prepared by the Judicial Performance  
4842 Evaluation Commission concerning a judge, unless Section [20A-7-702](#) or Title 78A, Chapter  
4843 12, Judicial Performance Evaluation Commission Act, requires disclosure of, or makes public,  
4844 the information or report;

4845 (56) records contained in the Management Information System created in Section  
4846 [62A-4a-1003](#);

4847 (57) records provided or received by the Public Lands Policy Coordinating Office in  
4848 furtherance of any contract or other agreement made in accordance with Section [63J-4-603](#);

4849 (58) information requested by and provided to the 911 Division under Section  
4850 [63H-7a-302](#);

4851 (59) in accordance with Section [73-10-33](#):

4852 (a) a management plan for a water conveyance facility in the possession of the Division  
4853 of Water Resources or the Board of Water Resources; or

4854 (b) an outline of an emergency response plan in possession of the state or a county or  
4855 municipality;

4856 (60) the following records in the custody or control of the Office of Inspector General  
4857 of Medicaid Services, created in Section [63A-13-201](#):

4858 (a) records that would disclose information relating to allegations of personal  
4859 misconduct, gross mismanagement, or illegal activity of a person if the information or  
4860 allegation cannot be corroborated by the Office of Inspector General of Medicaid Services  
4861 through other documents or evidence, and the records relating to the allegation are not relied

4862 upon by the Office of Inspector General of Medicaid Services in preparing a final investigation  
4863 report or final audit report;

4864 (b) records and audit workpapers to the extent they would disclose the identity of a  
4865 person who, during the course of an investigation or audit, communicated the existence of any  
4866 Medicaid fraud, waste, or abuse, or a violation or suspected violation of a law, rule, or  
4867 regulation adopted under the laws of this state, a political subdivision of the state, or any  
4868 recognized entity of the United States, if the information was disclosed on the condition that  
4869 the identity of the person be protected;

4870 (c) before the time that an investigation or audit is completed and the final  
4871 investigation or final audit report is released, records or drafts circulated to a person who is not  
4872 an employee or head of a governmental entity for the person's response or information;

4873 (d) records that would disclose an outline or part of any investigation, audit survey  
4874 plan, or audit program; or

4875 (e) requests for an investigation or audit, if disclosure would risk circumvention of an  
4876 investigation or audit;

4877 (61) records that reveal methods used by the Office of Inspector General of Medicaid  
4878 Services, the fraud unit, or the Department of Health, to discover Medicaid fraud, waste, or  
4879 abuse;

4880 (62) information provided to the Department of Health or the Division of Occupational  
4881 and Professional Licensing under Subsection 58-68-304(3) or (4);

4882 (63) a record described in Section 63G-12-210;

4883 (64) captured plate data that is obtained through an automatic license plate reader  
4884 system used by a governmental entity as authorized in Section 41-6a-2003;

4885 (65) any record in the custody of the Utah Office for Victims of Crime relating to a  
4886 victim, including:

4887 (a) a victim's application or request for benefits;

4888 (b) a victim's receipt or denial of benefits; and

4889 (c) any administrative notes or records made or created for the purpose of, or used to,  
4890 evaluate or communicate a victim's eligibility for or denial of benefits from the Crime Victim  
4891 Reparations Fund;

4892 (66) an audio or video recording created by a body-worn camera, as that term is

4893 defined in Section [77-7a-103](#), that records sound or images inside a hospital or health care  
4894 facility as those terms are defined in Section [78B-3-403](#), inside a clinic of a health care  
4895 provider, as that term is defined in Section [78B-3-403](#), or inside a human service program as  
4896 that term is defined in Subsection [62A-2-101\(19\)\(a\)\(vi\)](#), except for recordings that:

4897 (a) depict the commission of an alleged crime;

4898 (b) record any encounter between a law enforcement officer and a person that results in  
4899 death or bodily injury, or includes an instance when an officer fires a weapon;

4900 (c) record any encounter that is the subject of a complaint or a legal proceeding against  
4901 a law enforcement officer or law enforcement agency;

4902 (d) contain an officer involved critical incident as defined in Subsection  
4903 [76-2-408\(1\)\(d\)](#); or

4904 (e) have been requested for reclassification as a public record by a subject or  
4905 authorized agent of a subject featured in the recording; ~~[and]~~

4906 (67) a record pertaining to the search process for a president of an institution of higher  
4907 education described in Section [53B-2-102](#), except for application materials for a publicly  
4908 announced finalist~~[-]; and~~

4909 (68) work papers as defined in Section [31A-2-204](#).

4910 Section 51. Section [72-6-107.5](#) is amended to read:

4911 **[72-6-107.5. Construction of improvements of highway -- Contracts -- Health](#)**  
4912 **[insurance coverage.](#)**

4913 (1) ~~[For purposes of]~~ As used in this section:

4914 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
4915 related to a single project.

4916 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

4917 ~~[(a)]~~ (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee,"

4918 "worker," or "operative" ~~[as defined in Section [34A-2-104](#)]~~ who:

4919 (i) works at least 30 hours per calendar week; and

4920 (ii) meets employer eligibility waiting requirements for health care insurance, which  
4921 may not exceed the first day of the calendar month following 60 days ~~[from the date of hire]~~  
4922 after the day on which the individual is hired.

4923 ~~[(b)]~~ (d) "Health benefit plan" means the same as that term is defined in Section

4924 31A-1-301.

4925 ~~[(e)]~~ (e) "Qualified health insurance coverage" means the same as that term is defined  
4926 in Section 26-40-115.

4927 ~~[(d)]~~ (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

4928 ~~[(2)(a) Except as provided in Subsection (3), this section applies to contracts entered~~  
4929 ~~into by the department on or after July 1, 2009, for construction or design of highways and to a~~  
4930 ~~prime contractor or to a subcontractor in accordance with Subsection (2)(b).]~~

4931 ~~[(b) (i) A prime contractor is subject to this section if the prime contract is in the~~  
4932 ~~amount of \$2,000,000 or greater at the original execution of the contract.]~~

4933 ~~[(ii) A subcontractor is subject to this section if a subcontract is in the amount of~~  
4934 ~~\$1,000,000 or greater at the original execution of the contract.]~~

4935 ~~[(3) This section does not apply if:]~~

4936 (2) (a) Except as provided in Subsection (3), the requirements of this section apply to:

4937 (a) a contractor of a design or construction contract entered into by the department on  
4938 or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than  
4939 \$2,000,000; and

4940 (b) a subcontractor of a contractor of a design or construction contract entered into by  
4941 the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or  
4942 greater than \$1,000,000.

4943 (3) The requirements of this section do not apply to a contractor or subcontractor  
4944 described in Subsection (2) if:

4945 (a) the application of this section jeopardizes the receipt of federal funds;

4946 (b) the contract is a sole source contract; or

4947 (c) the contract is an emergency procurement.

4948 ~~[(4)(a) This section does not apply to a change order as defined in Section~~  
4949 ~~63G-6a-103, or a modification to a contract, when the contract does not meet the initial~~  
4950 ~~threshold required by Subsection (2).]~~

4951 ~~[(b)]~~ (4) A person ~~[who]~~ that intentionally uses change orders ~~[or]~~, contract  
4952 modifications, or multiple contracts to circumvent the requirements of ~~[Subsection (2)]~~ this  
4953 section is guilty of an infraction.

4954 (5) (a) A contractor subject to ~~[Subsection (2)]~~ the requirements of this section shall

4955 demonstrate to the department that the contractor has and will maintain an offer of qualified  
4956 health insurance coverage for the contractor's employees and the employees' dependents during  
4957 the duration of the contract[-] by submitting to the department a written statement that:

4958 ~~[(b) If a subcontractor of the contractor is subject to Subsection (2), the contractor~~  
4959 ~~shall:]~~

4960 (i) certifies that the contractor offers qualified health insurance coverage in accordance  
4961 with Section [26-40-115](#);

4962 (ii) is from:

4963 (A) an actuary selected by the contractor or the contractor's insurer; or

4964 (B) an underwriter who is responsible for developing the employer group's premium  
4965 rates; and

4966 (iii) was created within one year before the day on which the statement is submitted.

4967 (b) A contractor that is subject to the requirements of this section shall:

4968 (i) place a requirement in [the subcontract that the subcontractor] each of the  
4969 contractor's subcontracts that a subcontractor that is subject to the requirements of this section  
4970 shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's  
4971 employees and the employees' dependents during the duration of the subcontract; and

4972 ~~[(ii) certify to the department that the subcontractor has and will maintain an offer of~~  
4973 ~~qualified health insurance coverage for the subcontractor's employees and the employees'~~  
4974 ~~dependents during the duration of the prime contract.]~~

4975 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
4976 written statement that:

4977 (A) certifies that the subcontractor offers qualified health insurance coverage in  
4978 accordance with Section [26-40-115](#);

4979 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an  
4980 underwriter who is responsible for developing the employer group's premium rates; and

4981 (C) was created within one year before the day on which the contractor obtains the  
4982 statement.

4983 (c) (i) (A) A contractor [who fails to meet the requirements of] that fails to maintain an  
4984 offer of qualified health insurance coverage described in Subsection (5)(a) during the duration  
4985 of the contract is subject to penalties in accordance with administrative rules adopted by the

4986 department under Subsection (6).

4987 (B) A contractor is not subject to penalties for the failure of a subcontractor to ~~[meet~~  
4988 ~~the requirements of]~~ obtain and maintain an offer of qualified health insurance coverage  
4989 described in Subsection (5)(b)(i).

4990 (ii) (A) A subcontractor ~~[who fails to meet the requirements of]~~ that fails to obtain and  
4991 maintain an offer of qualified health insurance coverage described in Subsection (5)(b) during  
4992 the duration of the ~~[contract]~~ subcontract is subject to penalties in accordance with  
4993 administrative rules adopted by the department under Subsection (6).

4994 (B) A subcontractor is not subject to penalties for the failure of a contractor to ~~[meet~~  
4995 ~~the requirements of]~~ maintain an offer of qualified health insurance coverage described in  
4996 Subsection (5)(a).

4997 (6) The department shall adopt administrative rules:

4998 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

4999 (b) in coordination with:

5000 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

5001 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

5002 (iii) the State Building Board in accordance with Section ~~[[63A-5-205](#)]~~ [63A-5-205.5](#);

5003 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);

5004 (v) a public transit district in accordance with Section [17B-2a-818.5](#); and

5005 (vi) the Legislature's Administrative Rules Review Committee; and

5006 (c) that establish:

5007 (i) the requirements and procedures a contractor ~~[must]~~ and a subcontractor shall  
5008 follow to demonstrate ~~[to the department]~~ compliance with this section ~~[that shall include]~~,  
5009 including:

5010 ~~[(A) that a contractor shall demonstrate compliance with Subsection (5)(a) or (b) at the~~  
5011 ~~time of the execution of each initial contract described in Subsection (2)(b);]~~

5012 ~~[(B) that the contractor's]~~

5013 (A) that a contractor or subcontractor's compliance with this section is subject to an  
5014 audit by the department or the Office of the Legislative Auditor General; ~~[and]~~

5015 ~~[(C) that the actuarially equivalent determination required for qualified health~~  
5016 ~~insurance coverage in Subsection (1) is met by the contractor if the contractor provides the~~

5017 ~~department or division with a written statement of actuarial equivalency, which is no more than~~  
5018 ~~one year old, regarding the contractor's offer of qualified health coverage from an actuary~~  
5019 ~~selected by the contractor or the contractor's insurer, or an underwriter who is responsible for~~  
5020 ~~developing the employer group's premium rates;]~~

5021 (B) that a contractor that is subject to the requirements of this section shall obtain a  
5022 written statement described in Subsection (5)(a); and

5023 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
5024 written statement described in Subsection (5)(b)(ii);

5025 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
5026 violates the provisions of this section, which may include:

5027 (A) a three-month suspension of the contractor or subcontractor from entering into  
5028 future contracts with the state upon the first violation;

5029 (B) a six-month suspension of the contractor or subcontractor from entering into future  
5030 contracts with the state upon the second violation;

5031 (C) an action for debarment of the contractor or subcontractor in accordance with  
5032 Section [63G-6a-904](#) upon the third or subsequent violation; and

5033 (D) monetary penalties which may not exceed 50% of the amount necessary to  
5034 purchase qualified health insurance coverage for an employee and a dependent of the employee  
5035 of the contractor or subcontractor who was not offered qualified health insurance coverage  
5036 during the duration of the contract; and

5037 (iii) a website on which the department shall post the commercially equivalent  
5038 benchmark, for the qualified health insurance coverage identified in Subsection (1)~~(c)~~(e), that  
5039 is provided by the Department of Health, in accordance with Subsection [26-40-115\(2\)](#).

5040 (7) (a) (i) In addition to the penalties imposed under Subsection (6)~~(c)~~(ii), a contractor  
5041 or subcontractor who intentionally violates the provisions of this section [~~shall be~~] is liable to  
5042 the employee for health care costs that would have been covered by qualified health insurance  
5043 coverage.

5044 (ii) An employer has an affirmative defense to a cause of action under Subsection  
5045 (7)(a)(i) if:

5046 (A) the employer relied in good faith on a written statement [~~of actuarial equivalency~~  
5047 ~~provided by:~~] described in Subsection (5)(a) or (5)(b)(ii); or

5048 ~~[(F) an actuary; or]~~

5049 ~~[(H) an underwriter who is responsible for developing the employer group's premium~~  
5050 ~~rates; or]~~

5051 (B) the department determines that compliance with this section is not required under  
5052 the provisions of Subsection (3) ~~[or (4)].~~

5053 (b) An employee has a private right of action only against the employee's employer to  
5054 enforce the provisions of this Subsection (7).

5055 (8) Any penalties imposed and collected under this section shall be deposited into the  
5056 Medicaid Restricted Account created in Section [26-18-402](#).

5057 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
5058 coverage as required by this section:

5059 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
5060 or contractor under:

5061 (i) Section [63G-6a-1602](#); or

5062 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

5063 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
5064 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
5065 or construction.

5066 Section 52. Section **79-2-404** is amended to read:

5067 **79-2-404. Contracting powers of department -- Health insurance coverage.**

5068 (1) ~~[For purposes of]~~ As used in this section:

5069 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
5070 related to a single project.

5071 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

5072 ~~[(a)]~~ (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee,"

5073 "worker," or "operative" ~~[as defined in Section [34A-2-104](#)]~~ who:

5074 (i) works at least 30 hours per calendar week; and

5075 (ii) meets employer eligibility waiting requirements for health care insurance, which  
5076 may not exceed the first day of the calendar month following 60 days ~~[from the date of hire]~~  
5077 after the day on which the individual is hired.

5078 ~~[(b)]~~ (d) "Health benefit plan" means the same as that term is defined in Section

5079 31A-1-301.

5080 ~~[(e)]~~ (e) "Qualified health insurance coverage" means the same as that term is defined  
5081 in Section 26-40-115.

5082 ~~[(d)]~~ (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

5083 ~~[(2)(a) Except as provided in Subsection (3), this section applies a design or~~  
5084 ~~construction contract entered into by, or delegated to, the department or a division, board, or~~  
5085 ~~council of the department on or after July 1, 2009, and to a prime contractor or to a~~  
5086 ~~subcontractor in accordance with Subsection (2)(b).]~~

5087 ~~[(b)(i) A prime contractor is subject to this section if the prime contract is in the~~  
5088 ~~amount of \$2,000,000 or greater at the original execution of the contract.]~~

5089 ~~[(ii) A subcontractor is subject to this section if a subcontract is in the amount of~~  
5090 ~~\$1,000,000 or greater at the original execution of the contract.]~~

5091 (2) Except as provided in Subsection (3), the requirements of this section apply to:

5092 (a) a contractor of a design or construction contract entered into by, or delegated to, the  
5093 department or a division, board, or council of the department on or after July 1, 2009, if the  
5094 prime contract is in an aggregate amount equal to or greater than \$2,000,000; and

5095 (b) a subcontractor of a contractor of a design or construction contract entered into by,  
5096 or delegated to, the department or a division, board, or council of the department on or after  
5097 July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than \$1,000,000.

5098 (3) This section does not apply to contracts entered into by the department or a  
5099 division, board, or council of the department if:

5100 (a) the application of this section jeopardizes the receipt of federal funds;

5101 (b) the contract or agreement is between:

5102 (i) the department or a division, board, or council of the department; and

5103 (ii) (A) another agency of the state;

5104 (B) the federal government;

5105 (C) another state;

5106 (D) an interstate agency;

5107 (E) a political subdivision of this state; or

5108 (F) a political subdivision of another state; or

5109 (c) the contract or agreement is:

5110 (i) for the purpose of disbursing grants or loans authorized by statute;

5111 (ii) a sole source contract; or

5112 (iii) an emergency procurement.

5113 ~~[(4) (a) This section does not apply to a change order as defined in Section~~

5114 ~~63G-6a-103, or a modification to a contract, when the contract does not meet the initial~~

5115 ~~threshold required by Subsection (2).]~~

5116 ~~[(b)] (4) A person [who] that intentionally uses change orders [or], contract~~

5117 ~~modifications, or multiple contracts to circumvent the requirements of [Subsection (2)] this~~

5118 ~~section is guilty of an infraction.~~

5119 (5) (a) A contractor subject to ~~[Subsection (2)(b)(i)]~~ the requirements of this section

5120 shall demonstrate to the department that the contractor has and will maintain an offer of

5121 qualified health insurance coverage for the contractor's employees and the employees'

5122 dependents during the duration of the contract[-] by submitting to the department a written

5123 statement that:

5124 ~~[(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor~~

5125 ~~shall:]~~

5126 (i) certifies that the contractor offers qualified health insurance coverage in accordance

5127 with Section 26-40-115;

5128 (ii) is from:

5129 (A) an actuary selected by the contractor or the contractor's insurer; or

5130 (B) an underwriter who is responsible for developing the employer group's premium

5131 rates; and

5132 (iii) was created within one year before the day on which the statement is submitted.

5133 (b) A contractor that is subject to the requirements of this section shall:

5134 (i) place a requirement in [the subcontract that the subcontractor] each of the

5135 contractor's subcontracts that a subcontractor that is subject to the requirements of this section

5136 shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's

5137 employees and the employees' [dependants] dependents during the duration of the subcontract;

5138 and

5139 ~~[(ii) certify to the department that the subcontractor has and will maintain an offer of~~

5140 ~~qualified health insurance coverage for the subcontractor's employees and the employees'~~

5141 ~~dependents during the duration of the prime contract.]~~

5142 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
5143 written statement that:

5144 (A) certifies that the subcontractor offers qualified health insurance coverage in  
5145 accordance with Section [26-40-115](#);

5146 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an  
5147 underwriter who is responsible for developing the employer group's premium rates; and

5148 (C) was created within one year before the day on which the contractor obtains the  
5149 statement.

5150 (c) (i) (A) A contractor ~~[who fails to meet the requirements of]~~ that fails to maintain an  
5151 offer of qualified health insurance coverage described in Subsection (5)(a) during the duration  
5152 of the contract is subject to penalties in accordance with administrative rules adopted by the  
5153 department under Subsection (6).

5154 (B) A contractor is not subject to penalties for the failure of a subcontractor to ~~[meet~~  
5155 ~~the requirements of]~~ obtain and maintain an offer of qualified health insurance coverage  
5156 described in Subsection (5)(b)(i).

5157 (ii) (A) A subcontractor ~~[who fails to meet the requirements of]~~ that fails to obtain and  
5158 maintain an offer of qualified health insurance coverage described in Subsection (5)(b) during  
5159 the duration of the ~~[contract]~~ subcontract is subject to penalties in accordance with  
5160 administrative rules adopted by the department under Subsection (6).

5161 (B) A subcontractor is not subject to penalties for the failure of a contractor to ~~[meet~~  
5162 ~~the requirements of]~~ maintain an offer of qualified health insurance coverage described in  
5163 Subsection (5)(a).

5164 (6) The department shall adopt administrative rules:

5165 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

5166 (b) in coordination with:

5167 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

5168 (ii) a public transit district in accordance with Section [17B-2a-818.5](#);

5169 (iii) the State Building Board in accordance with Section ~~[[63A-5-205](#)]~~ [63A-5-205.5](#);

5170 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);

5171 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and

5172 (vi) the Legislature's Administrative Rules Review Committee; and  
5173 (c) that establish:

5174 (i) the requirements and procedures a contractor ~~[must]~~ and a subcontractor shall  
5175 follow to demonstrate compliance with this section ~~[to the department that shall include],~~  
5176 including:

5177 ~~[(A) that a contractor shall demonstrate compliance with Subsection (5)(a) or (b) at the~~  
5178 ~~time of the execution of each initial contract described in Subsection (2)(b);]~~

5179 ~~[(B) that the contractor's]~~

5180 (A) that a contractor or subcontractor's compliance with this section is subject to an  
5181 audit by the department or the Office of the Legislative Auditor General; ~~[and]~~

5182 ~~[(C) that the actuarially equivalent determination required for qualified health~~  
5183 ~~insurance coverage in Subsection (1) is met by the contractor if the contractor provides the~~  
5184 ~~department or division with a written statement of actuarial equivalency, which is no more than~~  
5185 ~~one year old, regarding the contractor's offer of qualified health coverage from an actuary~~  
5186 ~~selected by the contractor or the contractor's insurer, or an underwriter who is responsible for~~  
5187 ~~developing the employer group's premium rates;]~~

5188 (B) that a contractor that is subject to the requirements of this section shall obtain a  
5189 written statement described in Subsection (5)(a); and

5190 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
5191 written statement described in Subsection (5)(b)(ii);

5192 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
5193 violates the provisions of this section, which may include:

5194 (A) a three-month suspension of the contractor or subcontractor from entering into  
5195 future contracts with the state upon the first violation;

5196 (B) a six-month suspension of the contractor or subcontractor from entering into future  
5197 contracts with the state upon the second violation;

5198 (C) an action for debarment of the contractor or subcontractor in accordance with  
5199 Section [63G-6a-904](#) upon the third or subsequent violation; and

5200 (D) monetary penalties which may not exceed 50% of the amount necessary to  
5201 purchase qualified health insurance coverage for an employee and a dependent of an employee  
5202 of the contractor or subcontractor who was not offered qualified health insurance coverage

5203 during the duration of the contract; and

5204 (iii) a website on which the department shall post the commercially equivalent  
5205 benchmark, for the qualified health insurance coverage identified in Subsection (1)~~(c)~~(e),  
5206 provided by the Department of Health, in accordance with Subsection 26-40-115(2).

5207 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
5208 or subcontractor who intentionally violates the provisions of this section ~~[shall be]~~ is liable to  
5209 the employee for health care costs that would have been covered by qualified health insurance  
5210 coverage.

5211 (ii) An employer has an affirmative defense to a cause of action under Subsection  
5212 (7)(a)(i) if:

5213 (A) the employer relied in good faith on a written statement ~~[of actuarial equivalency~~  
5214 ~~provided by:]~~ described in Subsection (5)(a) or (5)(b)(ii); or

5215 ~~[(I) an actuary; or]~~

5216 ~~[(II) an underwriter who is responsible for developing the employer group's premium~~  
5217 ~~rates; or]~~

5218 (B) the department determines that compliance with this section is not required under  
5219 the provisions of Subsection (3) ~~[or (4)]~~.

5220 (b) An employee has a private right of action only against the employee's employer to  
5221 enforce the provisions of this Subsection (7).

5222 (8) Any penalties imposed and collected under this section shall be deposited into the  
5223 Medicaid Restricted Account created in Section 26-18-402.

5224 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
5225 coverage as required by this section:

5226 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
5227 or contractor under:

5228 (i) Section 63G-6a-1602; or

5229 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

5230 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
5231 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
5232 or construction.

5233 Section 53. **Repealer.**

5234 This bill repeals:

5235 Section [31A-22-722.5](#), Mini-COBRA election -- American Recovery and  
5236 **Reinvestment Act.**

5237 Section [31A-30-209](#), Insurance producers and the Health Insurance Exchange.