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H.B. 39
5th Sub. (Salmon)

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

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

coverage that certain contractors and subcontractors are required to obtain and maintain;

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

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

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

17B-2a-818.5, as last amended by Laws of Utah 2016, Chapters 20 and 355

19-1-206, as last amended by Laws of Utah 2016, Chapters 20 and 355

26-18-402, as last amended by Laws of Utah 2013, Chapter 278

26-40-115, as last amended by Laws of Utah 2016, Chapter 20

31A-1-301, as last amended by Laws of Utah 2017, Chapter 292

31A-2-201.1, as last amended by Laws of Utah 2008, Chapter 382

31A-2-201.2, as last amended by Laws of Utah 2017, Chapter 292

31A-2-204, as last amended by Laws of Utah 2008, Chapter 382

31A-2-403, as last amended by Laws of Utah 2015, Chapter 330

31A-3-303, as last amended by Laws of Utah 2011, Chapters 62 and 275

31A-3-304, as last amended by Laws of Utah 2017, Chapter 168

31A-6a-101, as last amended by Laws of Utah 2017, Chapter 27

31A-6a-104, as last amended by Laws of Utah 2016, Chapter 138

31A-6a-105, as last amended by Laws of Utah 2015, Chapter 244

31A-8-104, as last amended by Laws of Utah 1997, Chapter 185

31A-8a-102, as last amended by Laws of Utah 2013, Chapters 104 and 135

31A-15-103, as last amended by Laws of Utah 2017, Chapter 363

31A-16-103, as last amended by Laws of Utah 2015, Chapter 244

31A-22-612, as last amended by Laws of Utah 2015, Chapter 244

31A-22-618.6, as last amended by Laws of Utah 2017, Chapter 168 and renumbered and amended by Laws of Utah 2017, Chapter 292

31A-22-629, as last amended by Laws of Utah 2012, Chapter 253
31A-22-701, as last amended by Laws of Utah 2017, Chapter 168
31A-22-722, as last amended by Laws of Utah 2013, Chapter 319
31A-23a-107, as last amended by Laws of Utah 2012, Chapter 253
31A-23a-109, as last amended by Laws of Utah 2012, Chapter 253
31A-23a-111, as last amended by Laws of Utah 2017, Chapter 168
31A-23a-208, as enacted by Laws of Utah 2013, Chapter 341
31A-23a-406, as last amended by Laws of Utah 2013, Chapter 319
31A-23b-102, as last amended by Laws of Utah 2017, Chapter 168
31A-23b-202.5, as last amended by Laws of Utah 2017, Chapter 168
31A-23b-204, as enacted by Laws of Utah 2013, Chapter 341
31A-23b-205, as last amended by Laws of Utah 2014, Chapters 290, 300, 425 and last amended by Coordination Clause, Laws of Utah 2014, Chapters 300, and 425
31A-23b-206, as last amended by Laws of Utah 2015, Chapter 244
31A-25-204, as enacted by Laws of Utah 1985, Chapter 242
31A-25-206, as last amended by Laws of Utah 2001, Chapter 116
31A-26-102, as last amended by Laws of Utah 2014, Chapters 290 and 300
31A-26-205, as last amended by Laws of Utah 1986, Chapter 204
31A-26-208, as last amended by Laws of Utah 2011, Chapter 284
31A-27a-111, as enacted by Laws of Utah 2007, Chapter 309
31A-27a-608, as enacted by Laws of Utah 2007, Chapter 309
31A-30-210, as enacted by Laws of Utah 2010, Chapter 229
31A-43-303, as last amended by Laws of Utah 2014, Chapters 290 and 300
34A-2-107, as last amended by Laws of Utah 2017, Chapters 18 and 363
34A-2-705, as last amended by Laws of Utah 2011, Chapter 328
63A-5-205, as last amended by Laws of Utah 2016, Chapters 20 and 355
63C-9-403, as last amended by Laws of Utah 2016, Chapters 20 and 355
63G-2-305, as last amended by Laws of Utah 2017, Chapters 374, 382, and 415
72-6-107.5, as last amended by Laws of Utah 2016, Chapters 20 and 355
79-2-404, as last amended by Laws of Utah 2016, Chapters 20 and 355

ENACTS:

31A-45-403, Utah Code Annotated 1953

63A-5-205.5, Utah Code Annotated 1953

REPEALS AND REENACTS:

31A-6a-111, as enacted by Laws of Utah 2015, Chapter 244

REPEALS:

31A-22-722.5, as last amended by Laws of Utah 2011, Chapters 297 and 340

31A-30-209, as last amended by Laws of Utah 2016, Chapter 138

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

Section 1. Section **17B-2a-818.5** is amended to read:

17B-2a-818.5. Contracting powers of public transit districts -- Health insurance coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) the contract is an emergency procurement.

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

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

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

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

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

(ii) is from:

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

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

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

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

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

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

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

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

(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an underwriter who is responsible for developing the employer group's premium rates; and

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

(c) (i) (A) A contractor [~~who fails to meet the requirements of~~] that fails to maintain an offer of qualified health insurance coverage as described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with an ordinance adopted by the public transit district under Subsection (6).

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

(ii) (A) A subcontractor [~~who fails to meet the requirements of~~] that fails to obtain and maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i)

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

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

(6) The public transit district shall adopt ordinances:

(a) in coordination with:

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

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

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

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

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

(b) that establish:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[~~(I) actuary; or~~]

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

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

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

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

Medicaid Restricted Account created in Section 26-18-402.

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

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

(i) Section 63G-6a-1602; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) the contract or agreement is between:

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

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

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state;

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

(d) the contract is:

(i) a sole source contract; or

(ii) an emergency procurement.

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

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

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

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

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

(ii) is from:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) that establish:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[~~(I) an actuary; or~~]

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

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

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

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

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

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

(i) Section 63G-6a-1602; or

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

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

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

26-18-402. Medicaid Restricted Account.

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

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

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

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

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

(iii) any penalties imposed and collected under:

(A) Section 17B-2a-818.5;

(B) Section 19-1-206;

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

(C) Subsection 63A-5-205.5;

(D) Section 63C-9-403;

(E) Section 72-6-107.5; or

(F) Section 79-2-404.

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

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

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

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

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

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

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

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

the contract is entered into or renewed:

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

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

(i) has a deductible that is:

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

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

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

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

(2) The department shall:

(a) on or before July 1, 2016:

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

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

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

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

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

economic losses resulting from:

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

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

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

(3) "Administrator" means the same as that term is defined in Subsection [~~(170)~~] (171).

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

(5) "Affiliate" means a person who controls, is controlled by, or is under common control with, another person. A corporation is an affiliate of another corporation, regardless of

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

(6) "Agency" means:

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

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

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

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

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

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

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

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

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

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

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

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

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

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

(a) without individual underwriting or application; and

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

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

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

(a) that is open to the public;

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

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

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

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

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

(a) Section 31A-7-201;

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

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

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

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

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by another organization; and

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

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

(i) owned by the insureds; and

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

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

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

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

(b) a third party.

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

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

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

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

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

supervisory official of another jurisdiction.

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

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

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

(A) for the life of the insured; or

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

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

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

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

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

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

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

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

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

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

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

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

(I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

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

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

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

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

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

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

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

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

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

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(39) "Credit property insurance" means insurance:

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

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

(40) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

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

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

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

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

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

(ii) to the customer service representative's employer's:

(A) customer;

(B) client; or

(C) organization.

(b) A customer service representative may only operate within the scope of authority of the customer service representative's producer, surplus lines producer, or consultant employer.

(43) "Deadline" means a final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

(b) by which a required filing or payment must be received by the department.

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

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

(46) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

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

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

(ii) a person described in Subsection (52)(b).

(b) "Eligible employee" includes:

(i) an owner who:

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

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

(ii) if the individual is included under a health benefit plan of a small employer:

(A) a sole proprietor;

(B) a partner in a partnership; or

(C) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):

(i) an individual who works on a temporary or substitute basis for a small employer;

(ii) an employer's spouse who does not meet the requirements of Subsection (52)(a)(i); or

(iii) a dependent of an employer who does not meet the requirements of Subsection (52)(a)(i).

(53) "Employee" means:

(a) an individual employed by an employer; and

(b) an owner who meets the requirements of Subsection (52)(b)(i).

(54) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

(55) (a) "Employee welfare fund" means a fund:

(i) established or maintained, whether directly or through a trustee, by:

(A) one or more employers;

(B) one or more labor organizations; or

(C) a combination of employers and labor organizations; and

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund:

(A) by or on behalf of an employer doing business in this state; or

(B) for the benefit of a person employed in this state.

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

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

(57) (a) "Enrollee" means:

(i) a policyholder;

(ii) a certificate holder;

(iii) a subscriber; or

(iv) a covered individual:

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

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

(b) "Enrollee" includes an insured.

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

(a) the first day of coverage; or

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

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

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

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

(60) (a) "Escrow" means:

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

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

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

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" does not include:

(i) the following notarial acts performed by a notary within the state:

(A) an acknowledgment;

(B) a copy certification;

(C) jurat; and

(D) an oath or affirmation;

(ii) the receipt or delivery of a document; or

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

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

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

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

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

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

(d) a specific prescription drug or class of prescription drugs.

(64) "Expense reimbursement insurance" means insurance:

(a) written to provide a payment for an expense relating to hospital confinement resulting from illness or injury; and

(b) written:

(i) as a daily limit for a specific number of days in a hospital; and

(ii) to have a one or two day waiting period following a hospitalization.

(65) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding

a position of public or private trust.

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

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

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

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

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

(B) rule.

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

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

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement;

(o) a binder; or

(p) an outline of coverage.

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

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

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

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

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

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

(72) "General lines of authority" include:

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

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

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

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

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

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

(73) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

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

plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

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

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

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

(A) the policy; or

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

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

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

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

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

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

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

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

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics;

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

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

(A) limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

(79) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

(b) "Health care insurance" or "health insurance" does not include accident and health insurance providing a benefit for:

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

(x) a type of accident and health insurance coverage that is a part of or attached to another type of policy.

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

(81) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec. 155.20.

[~~(81)~~] (82) "Health Insurance Portability and Accountability Act" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.

[~~(82)~~] (83) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(83)~~] (84) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(84)~~] (85) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

[~~(85)~~] (86) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(86)~~] (87) "Individual" means a natural person.

[~~(87)~~] (88) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

(b) property in transit over water by means other than boat or ship;

(c) bailee liability;

(d) fixed transportation property such as bridges, electric transmission systems, radio and television transmission towers and tunnels; and

(e) personal and commercial property floaters.

[~~(88)~~] (89) "Insolvency" or "insolvent" means that:

(a) an insurer is unable to pay [~~its debts or meet its obligations as the debts and obligations mature~~] the insurer's obligations as the obligations are due;

(b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC under Subsection 31A-17-601(8)(c); or

(c) an [~~insurer is determined to be hazardous under this title~~] insurer's admitted assets are less than the insurer's liabilities.

[~~(89)~~] (90) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

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

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

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

[~~(90)~~] (91) "Insurance adjuster" means a person who directs or conducts the investigation, negotiation, or settlement of a claim under an insurance policy other than life

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

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

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

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

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

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

(c) providing an annuity:

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

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

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

(e) providing another person with insurance;

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections [~~(91)~~] (92)(a) through (h) in a manner designed to evade this title.

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

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

(i) applies only to this title;

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

(iii) includes an enrollee.

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

(i) a fraternal benefit society;

(ii) an issuer of a gift annuity other than an annuity specified in Subsections 31A-22-1305(2) and (3);

(iii) a motor club;

(iv) an employee welfare plan;

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

(vi) a health maintenance organization.

(b) "Insurer" does not include a governmental entity to the extent the governmental entity is engaged in an activity described in Section 31A-12-107.

[~~(97)~~] (98) "Interinsurance exchange" means the same as that term is defined in Subsection [~~(152)~~] (153).

[~~(98)~~] (99) "Involuntary unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

[~~(99)~~] (100) (a) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

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

[~~(100)~~] (101) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

[~~(101)~~] (102) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

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

(b) through special enrollment.

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

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

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

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

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

(ii) for a medical, hospital, surgical, and funeral benefit to a person other than the insured who is injured, irrespective of legal liability of the insured, when issued with or supplemental to insurance against legal liability for the death, injury, or disability of a human being, exclusive of the coverages under:

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

(iii) for loss or damage to property resulting from an accident to or explosion of a boiler, pipe, pressure container, machinery, or apparatus;

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

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

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

(v) for other loss or damage properly the subject of insurance not within another kind of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

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

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

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

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

(i) insurance on a human life; and

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

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

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

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

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

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

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

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

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

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

(i) is limited to partially or wholly extinguishing the credit obligation; and

(ii) the commissioner determines by rule should be designated as a form of limited line credit insurance.

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

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

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

(k) another form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

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

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

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

(i) in a setting other than an acute care unit of a hospital;

(ii) for not less than 12 consecutive months for a covered person on the basis of:

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(112)~~] (113)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

(b) "Long-term care insurance" includes:

(i) any of the following that provide directly or supplement long-term care insurance:

(A) a group or individual annuity or rider; or

(B) a life insurance policy or rider;

(ii) a policy or rider that provides for payment of benefits on the basis of:

(A) cognitive impairment; or

(B) functional capacity; or

(iii) a qualified long-term care insurance contract.

(c) "Long-term care insurance" does not include:

(i) a policy that is offered primarily to provide basic Medicare supplement coverage;

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

(vi) income replacement or related asset-protection coverage;

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

(x) a life insurance policy that accelerates the death benefit to provide the option of a lump sum payment:

(A) if the following are not conditioned on the receipt of long-term care:

(I) benefits; or

(II) eligibility; and

(B) the coverage is for one or more the following qualifying events:

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

[~~(113)~~] (114) "Managed care organization" means a person:

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

(b) (i) licensed under:

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

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

(C) Chapter 14, Foreign Insurers; and

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

[~~(114)~~] (115) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

[~~(115)~~] (116) "Member" means a person having membership rights in an insurance corporation.

[~~(116)~~] (117) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

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

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

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

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

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections [~~(120)~~] (121)(b)(iii)(A) through (D); or

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

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

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

(a) that is issued by an insurer; and

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

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

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

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

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

(a) ships or hulls of ships;

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

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

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

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

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

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

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

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

(b) receives:

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

(ii) another government health benefit.

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

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

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

[~~(131)~~] (132) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

[~~(132)~~] (133) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec. 1002(16)(B).

[~~(133)~~] (134) "Plan year" means:

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection [~~(133)~~] (134)(a) or (b), the calendar year.

[~~(134)~~] (135) (a) "Policy" means a document, including an attached endorsement or application that:

(i) purports to be an enforceable contract; and

(ii) memorializes in writing some or all of the terms of an insurance contract.

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

(i) a motor club under Chapter 11, Motor Clubs;

(ii) a service contract provided under Chapter 6a, Service Contracts; and

(iii) a corporation licensed under:

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

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

(c) "Policy" does not include:

(i) a certificate under a group insurance contract; or

(ii) a document that does not purport to have legal effect.

[~~(135)~~] (136) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(136)~~] (137) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

[~~(137)~~] (138) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(138)~~] (139) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal regulations and guidance.

[~~(139)~~] (140) "Preexisting condition," with respect to [~~a health benefit plan~~] health care insurance:

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

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

[~~(140)~~] (141) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

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

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

[~~(141)~~] (142) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(142)~~] (143) "Proceeding" includes an action or special statutory proceeding.

[~~(143)~~] (144) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

[~~(144)~~] (145) (a) Except as provided in Subsection [~~(144)~~] (145)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

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

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

[~~(145)~~] (146) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(146)~~] (147) "Qualified United States financial institution" means an institution that:

(a) is:

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

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

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

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

(i) the commissioner by rule; or

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

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

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

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

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

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

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

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

(d) a rating formula that describes steps, policies, and procedures for determining initial and renewal policy premiums.

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

(i) a refund of premium or portion of premium;

(ii) a refund of commission or portion of commission;

(iii) a refund of all or a portion of a consultant fee; or

(iv) providing services or other benefits not specified in an insurance or annuity contract.

(b) "Rebate" does not include:

(i) a refund due to termination or changes in coverage;

(ii) a refund due to overcharges made in error by the licensee; or

(iii) savings or wellness benefits as provided in the contract by the licensee.

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

(a) the date delivered to and stamped received by the department, if delivered in person;

(b) the post mark date, if delivered by mail;

(c) the delivery service's post mark or pickup date, if delivered by a delivery service;

(d) the received date recorded on an item delivered, if delivered by:

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

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

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

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

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

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

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

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

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

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

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

(a) an insurance policy; or

(b) an insurance certificate.

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

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

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(159)~~] (160)(a)(i) through (xiv); or

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

(b) "Security" does not include:

(i) any of the following under which an insurance company promises to pay money in a specific lump sum or periodically for life or some other specified period:

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

[~~(160)~~] (161) "Securityholder" means a specified person who owns a security of a person, including:

(a) common stock;

(b) preferred stock;

(c) debt obligations; and

(d) any other security convertible into or evidencing the right of any of the items listed in this Subsection [~~(160)~~] (161).

[~~(161)~~] (162) (a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

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

(c) "Self-insurance" includes:

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

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

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

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

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) bail bond insurance; and

(c) fidelity insurance.

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

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

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

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

(c) "Excess surplus" means:

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

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

(I) 2.5; and

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

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

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(170)~~] (171) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

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

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

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

(c) an employer on behalf of the employer's employees or the employees of one or more of the subsidiary or affiliated corporations of the employer;

(d) an insurer licensed under the following, but only for a line of insurance for which the insurer holds a license in this state:

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

(ii) Chapter 7, Nonprofit Health Service Insurance Corporations;

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

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

(A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries; or

(B) Chapter 26, Insurance Adjusters; and

(ii) whose activities are limited to those authorized under the license the person holds or for which the person is exempt; or

(f) an institution, bank, or financial institution:

(i) that is:

(A) an institution whose deposits and accounts are to any extent insured by a federal deposit insurance agency, including the Federal Deposit Insurance Corporation or National Credit Union Administration; or

(B) a bank or other financial institution that is subject to supervision or examination by a federal or state banking authority; and

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

[~~(171)~~] (172) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(172)~~] (173) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

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

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

[~~(173)~~] (174) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

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

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

31A-2-201.1. General filing requirements.

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

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

(1) a form;

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

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

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

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

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

(1) Each year the commissioner shall:

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

(b) report the findings of the evaluation to the Health and Human Services Interim Committee before [~~October~~] December 1 of each year; and

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

(2) The evaluation required by this section shall:

(a) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of the state, and includes an analysis of:

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

(ii) rate changes;

(iii) coverage and demographic changes;

(iv) benefit trends;

(v) market share changes; and

(vi) accessibility;

(b) assess complaint ratios and trends within the health insurance market, which assessment shall include complaint data from the Office of Consumer Health Assistance within the department;

(c) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and

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

(3) When preparing the evaluation and report required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others

with an interest in the health insurance market.

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

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

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

31A-2-204. Conducting examinations.

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

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

(b) in drafting an examination report.

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

(i) stating the scope of the examination; and

(ii) designating the examiner in charge.

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

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

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

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

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

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

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

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

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

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

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

(a) the examinee; and

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

(i) an officer of the examinee;

(ii) any other person who:

(A) has executive authority over the examinee; or

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

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

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

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

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

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

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

(ii) the examiner's recommendations.

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

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

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

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

(i) accept the examination report as written; or

(ii) request agency action to modify the examination report.

(c) The report is considered accepted under this Subsection [~~(7)~~] (8) if the examinee does not file a request for agency action to modify the report within 20 days after service of the report.

(d) If the examination report is accepted:

(i) the examination report immediately becomes a public document; and

(ii) the commissioner shall distribute the examination report to all jurisdictions in which the examinee is authorized to do business.

(e) (i) Any adjudicative proceeding held as a result of the examinee's request for agency action shall, upon the examinee's demand, be closed to the public, except that the commissioner need not exclude any participating examiner from this closed hearing.

(ii) Within 20 days after the hearing held under this Subsection [~~(7)~~] (8)(e), the commissioner shall:

(A) adopt the examination report with any necessary modifications; and

(B) serve a copy of the adopted report upon the examinee.

(iii) Unless the examinee seeks judicial relief, the adopted examination report:

(A) shall become a public document 10 days after service; and

(B) may be distributed as described in this section.

(f) Notwithstanding Title 63G, Chapter 4, Administrative Procedures Act, to the extent that this section is in conflict with Title 63G, Chapter 4, Administrative Procedures Act, this section governs:

(i) a request for agency action under this section; or

(ii) adjudicative proceeding under this section.

[~~(8)~~] (9) The examinee shall promptly furnish copies of the adopted examination report described in Subsection [~~(7)~~] (8) to each member of the examinee's board.

[~~(9)~~] (10) After an examination report becomes a public document under Subsection [~~(7)~~] (8), the commissioner may furnish, without cost or at a reasonable price set under Section 31A-3-103, a copy of the examination report to interested persons, including:

(a) a member of the board of the examinee; or

(b) one or more newspapers in this state.

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

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

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

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

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

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

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

(ii) two members shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

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

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

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

(b) The commissioner may call additional meetings:

(i) at the commissioner's discretion;

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

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

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

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

(7) The commissioner shall staff the commission.

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

31A-3-303. Payment of tax.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner shall:

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

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

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

subject to the relevant sanctions of this title.

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

(i) a fee under this section;

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

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

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

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

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

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

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

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

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

(i) administer and enforce:

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

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

(ii) promote the captive insurance industry in Utah.

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

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

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

[~~(iii)~~] (i) for fiscal year 2017-2018 and subsequent fiscal years, in excess of $1,850,000[~~.~~]; and

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

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

31A-6a-101. Definitions.

As used in this chapter:

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

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

[~~(1)~~] (2) "Mechanical breakdown insurance" means a policy, contract, or agreement issued by an insurance company that has complied with either Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, that undertakes to perform or provide repair or replacement service on goods or property, or indemnification for repair or replacement service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear.

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

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

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

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

emergency road service, and covering food spoilage.

(b) "Service contract" does not include:

(i) mechanical breakdown insurance; or

(ii) a prepaid contract of limited duration that provides for scheduled maintenance only, regardless of whether the contract is executed before, on, or after May 9, 2017.

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

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

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

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

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

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

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

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

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

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

(ii) designed to:

(A) prevent the theft of the vehicle[~~.~~]; or

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

(b) "Vehicle protection product" includes:

(i) a vehicle protection product warranty;

(ii) an alarm system;

(iii) a body part marking product;

(iv) a steering lock;

(v) a window etch product;

(vi) a pedal and ignition lock;

(vii) a fuel and ignition kill switch; and

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

[~~(9)~~] (10) "Vehicle protection product warranty" means a written agreement by a warrantor that provides that if the vehicle protection product fails to prevent the theft of the motor vehicle, [~~that~~] or aid in the recovery of the motor vehicle within a time period specified in the warranty, not exceeding 30 days after the day on which the motor vehicle is reported stolen, the warrantor will reimburse the warranty holder [~~under the warranty in a fixed amount~~] for incidental costs specified in the warranty, not [~~to exceed $5,000~~] exceeding $5,000, or in a specified fixed amount not exceeding $5,000.

[~~(10)~~] (11) "Warrantor" means a person who is contractually obligated to the warranty holder under the terms of a vehicle protection product warranty.

[~~(11)~~] (12) "Warranty holder" means the person who purchases a vehicle protection product, any authorized transferee or assignee of the purchaser, or any other person legally assuming the purchaser's rights under the vehicle protection product warranty.

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

31A-6a-104. Required disclosures.

(1) A [~~service contract~~] reimbursement insurance policy insuring a service contract or a vehicle protection product warranty that is issued, sold, or offered for sale in this state shall conspicuously state that, upon failure of the service contract provider or warrantor to perform under the contract, the issuer of the policy shall:

(a) pay on behalf of the service contract provider or warrantor any sums the service contract provider or warrantor is legally obligated to pay according to the service contract provider's or warrantor's contractual obligations under the service contract or a vehicle

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

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

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

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

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

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

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

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

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

(iii) as applicable:

(A) "The warrantor under this vehicle protection product warranty will reimburse the warranty holder as specified in the warranty upon the theft of the vehicle"; or

(B) "The warrantor under this vehicle protection product warranty will reimburse the warranty holder as specified in the warranty and at the end of the time period specified in the warranty if, following the theft of the vehicle, the stolen vehicle is not recovered within a time

period specified in the warranty, not to exceed 30 days after the day on which the vehicle is reported stolen."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) immediately below the printed disclosure; and

(B) at or before the time the consumer purchases the vehicle protection product.

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

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

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

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

31A-6a-105. Prohibited acts.

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

(a) any of the following words:

(i) "insurance";

(ii) "casualty";

(iii) "surety";

(iv) "mutual"; or

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

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

(i) an insurance or surety corporation; or

(ii) another service contract provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

other contract.

(2) If a vehicle protection product is represented as preventing the theft of a vehicle, the vehicle protection product warranty shall, at a minimum, provide for reimbursement of damage a theft causes to the motor vehicle up to $5,000, if the vehicle is recovered within the time period specified in the warranty following the theft of the vehicle, not to exceed 30 days after the day on which the vehicle is reported stolen.

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

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

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

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

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

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

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

[~~(3) In determining whether the requirements of Subsection (1) are satisfied, the commissioner shall rely on the findings of the director of the Department of Health delivered to the commissioner in accordance with Subsection (2).~~]

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

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

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

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

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

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

31A-8a-102. Definitions.

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

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

(2) "Health care provider" means a health care provider as defined in Section 78B-3-403, with the exception of "licensed athletic trainer," who:

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

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

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

(b) "Health discount program" does not include a program that does not charge a membership fee or require other consideration from the member to use the program's discounts

for health services.

(4) "Health discount program marketer" means a person, including a private label entity, that markets, promotes, sells, or distributes a health discount program but does not operate a health discount program.

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

(6) "Marketing" means making or causing to be made any communication that contains information that relates to a product or contract regulated under this chapter.

[~~(6)~~] (7) "Value-added benefit" means a discount offering with no additional charge made by a health insurer or health maintenance organization that is licensed under this title, in connection with existing contracts with the health insurer or health maintenance organization.

Section 18. Section **31A-15-103** is amended to read:

31A-15-103. Surplus lines insurance -- Unauthorized insurers.

(1) Notwithstanding Section 31A-15-102, [~~a foreign insurer that has not obtained a certificate of authority to do business in this state under Section 31A-14-202 may negotiate for and~~] when this state is the home state as defined in Section 31A-3-305, a nonadmitted insurer may make an insurance contract [~~with~~] for coverage of a person in this state and on a risk located in this state, subject to the limitations and requirements of this section.

(2) (a) For a contract made under this section, the insurer may, in this state:

(i) inspect the risks to be insured;

(ii) collect premiums;

(iii) adjust losses; and

(iv) do another act reasonably incidental to the contract.

(b) An act described in Subsection (2)(a) may be done through:

(i) an employee; or

(ii) an independent contractor.

(3) (a) Subsections (1) and (2) do not permit a person to solicit business in this state on behalf of an insurer that has no certificate of authority.

(b) Insurance placed with a nonadmitted insurer shall be placed [~~with~~] by a surplus

lines producer licensed under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(c) The commissioner may by rule prescribe how a surplus lines producer may:

(i) pay or permit the payment, commission, or other remuneration on insurance placed by the surplus lines producer under authority of the surplus lines producer's license to one holding a license to act as an insurance producer; and

(ii) advertise the availability of the surplus lines producer's services in procuring, on behalf of a person seeking insurance, a contract with a nonadmitted insurer.

(4) For a contract made under this section, a nonadmitted insurer is subject to Sections 31A-23a-402, 31A-23a-402.5, and 31A-23a-403 and the rules adopted under those sections.

(5) A nonadmitted insurer may not issue workers' compensation insurance coverage to an employer located in this state, except for stop loss coverage issued to an employer securing workers' compensation under Subsection 34A-2-201(2).

(6) (a) The commissioner may by rule prohibit making a contract under Subsection (1) for a specified class of insurance if authorized insurers provide an established market for the class in this state that is adequate and reasonably competitive.

(b) The commissioner may by rule place a restriction or a limitation on and create special procedures for making a contract under Subsection (1) for a specified class of insurance if:

(i) there have been abuses of placements in the class; or

(ii) the policyholders in the class, because of limited financial resources, business experience, or knowledge, cannot protect their own interests adequately.

(c) The commissioner may prohibit an individual insurer from making a contract under Subsection (1) and all insurance producers from dealing with the insurer if:

(i) the insurer willfully violates:

(A) this section;

(B) Section 31A-4-102, 31A-23a-402, 31A-23a-402.5, or 31A-26-303; or

(C) a rule adopted under a section listed in Subsection (6)(c)(i)(A) or (B);

(ii) the insurer fails to pay the fees and taxes specified under Section 31A-3-301; or

(iii) the commissioner has reason to believe that the insurer is:

(A) in an unsound condition;

(B) operated in a fraudulent, dishonest, or incompetent manner; or

(C) in violation of the law of its domicile.

(d) (i) The commissioner may issue one or more lists of [~~unauthorized~~] nonadmitted foreign insurers whose:

(A) solidity the commissioner doubts; or

(B) practices the commissioner considers objectionable.

(ii) The commissioner shall issue one or more lists of [~~unauthorized~~] nonadmitted foreign insurers the commissioner considers to be reliable and solid.

(iii) In addition to the lists described in Subsections (6)(d)(i) and (ii), the commissioner may issue other relevant evaluations of [~~unauthorized~~] nonadmitted insurers.

(iv) An action may not lie against the commissioner or an employee of the department for a written or oral communication made in, or in connection with the issuance of, a list or evaluation described in this Subsection (6)(d).

(e) A foreign [~~unauthorized~~] nonadmitted insurer shall be listed on the commissioner's "reliable" list only if the [~~unauthorized~~] nonadmitted insurer:

(i) delivers a request to the commissioner to be on the list;

(ii) establishes satisfactory evidence of good reputation and financial integrity;

(iii) (A) delivers to the commissioner a copy of the [~~unauthorized~~] nonadmitted insurer's current annual statement certified by the insurer[~~; and~~] and, each subsequent year, delivers to the commissioner a copy of the nonadmitted insurer's annual statement within 60 days after the day on which the nonadmitted insurer files the annual statement with the insurance regulatory authority where the nonadmitted insurer is domiciled; or

[~~(B) continues each subsequent year to file its annual statements with the commissioner within 60 days of the day on which it is filed with the insurance regulatory authority where the insurer is domiciled;~~]

(B) files the nonadmitted insurer's annual statements with the National Association of Insurance Commissioners and the nonadmitted insurer's annual statements are available electronically from the National Association of Insurance Commissioners;

(iv) (A) [~~(I)~~] is in substantial compliance with the solvency standards in Chapter 17, Part 6, Risk-Based Capital, or maintains capital and surplus of at least $15,000,000, whichever is greater; [~~and~~] or

[~~(II) maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, or maintains a deposit meeting the statutory deposit requirements for insurers in the state where it is made, which trust fund or deposit:~~]

[~~(Aa) shall be in an amount not less than $2,500,000 for the protection of all of the insurer's policyholders in the United States;~~]

[~~(Bb) may consist of cash, securities, or investments of substantially the same character and quality as those which are "qualified assets" under Section 31A-17-201; and~~]

[~~(Cc) may include as part of the trust arrangement a letter of credit that qualifies as acceptable security under Section 31A-17-404.1; or~~]

(B) in the case of any "Lloyd's" or other similar incorporated or unincorporated group of alien individual insurers, maintains a trust fund that:

(I) shall be in an amount not less than $50,000,000 as security to its full amount for all policyholders and creditors in the United States of each member of the group;

(II) may consist of cash, securities, or investments of substantially the same character and quality as those which are "qualified assets" under Section 31A-17-201; and

(III) may include as part of this trust arrangement a letter of credit that qualifies as acceptable security under Section 31A-17-404.1; and

(v) for an alien insurer not domiciled in the United States or a territory of the United States, is listed on the Quarterly Listing of Alien Insurers maintained by the National Association of Insurance Commissioners International Insurers Department.

(7) (a) Subject to Subsection (7)(b), a surplus lines producer may not, either knowingly or without reasonable investigation of the financial condition and general reputation of the insurer, place insurance under this section with:

(i) a financially unsound insurer;

(ii) an insurer engaging in unfair practices; or

(iii) an otherwise substandard insurer.

(b) A surplus line producer may place insurance under this section with an insurer described in Subsection (7)(a) if the surplus line producer:

(i) gives the applicant notice in writing of the known deficiencies of the insurer or the limitations on the surplus line producer's investigation; and

(ii) explains the need to place the business with that insurer.

(c) A copy of the notice described in Subsection (7)(b) shall be kept in the office of the surplus line producer for at least five years.

(d) To be financially sound, an insurer shall satisfy standards that are comparable to those applied under the laws of this state to an authorized insurer.

(e) An insurer on the "doubtful or objectionable" list under Subsection (6)(d) or an insurer not on the commissioner's "reliable" list under Subsection (6)(e) is presumed substandard.

(8) (a) A policy issued under this section shall:

(i) include a description of the subject of the insurance; and

(ii) indicate:

(A) the coverage, conditions, and term of the insurance;

(B) the premium charged the policyholder;

(C) the premium taxes to be collected from the policyholder; and

(D) the name and address of the policyholder and insurer.

(b) If the direct risk is assumed by more than one insurer, the policy shall state:

(i) the names and addresses of all insurers; and

(ii) the portion of the entire direct risk each assumes.

(c) A policy issued under this section shall have attached or affixed to the policy the following statement: "The insurer issuing this policy does not hold a certificate of authority to do business in this state and thus is not fully subject to regulation by the Utah insurance commissioner. This policy receives no protection from any of the guaranty associations created under Title 31A, Chapter 28, Guaranty Associations."

(9) Upon placing a new or renewal coverage under this section, a surplus lines producer shall promptly deliver to the policyholder or the policyholder's agent evidence of the insurance consisting either of:

(a) the policy as issued by the insurer; or

(b) if the policy is not available upon placing the coverage, a certificate, cover note, or other confirmation of insurance complying with Subsection (8).

(10) If the commissioner finds it necessary to protect the interests of insureds and the public in this state, the commissioner may by rule subject a policy issued under this section to as much of the regulation provided by this title as is required for a comparable policy written

by an authorized foreign insurer.

(11) (a) A surplus lines transaction in this state shall be examined to determine whether it complies with:

(i) the surplus lines tax levied under Chapter 3, Department Funding, Fees, and Taxes;

(ii) the solicitation limitations of Subsection (3);

(iii) the requirement of Subsection (3) that placement be through a surplus lines producer;

(iv) placement limitations imposed under Subsections (6)(a), (b), and (c); and

(v) the policy form requirements of Subsections (8) and (10).

(b) The examination described in Subsection (11)(a) shall take place as soon as practicable after the transaction. The surplus lines producer shall submit to the examiner information necessary to conduct the examination within a period specified by rule.

(c) (i) The examination described in Subsection (11)(a) may be conducted by the commissioner or by an advisory organization created under Section 31A-15-111 and authorized by the commissioner to conduct these examinations. The commissioner is not required to authorize an additional advisory organization to conduct an examination under this Subsection (11)(c).

(ii) The commissioner's authorization of one or more advisory organizations to act as examiners under this Subsection (11)(c) shall be:

(A) by rule; and

(B) evidenced by a contract, on a form provided by the commissioner, between the authorized advisory organization and the department.

(d) (i) (A) A person conducting the examination described in Subsection (11)(a) shall collect a stamping fee of an amount not to exceed 1% of the policy premium payable in connection with the transaction.

(B) A stamping fee collected by the commissioner shall be deposited in the General Fund.

(C) The commissioner shall establish a stamping fee by rule.

(ii) A stamping fee collected by an advisory organization is the property of the advisory organization to be used in paying the expenses of the advisory organization.

(iii) Liability for paying a stamping fee is as required under Subsection 31A-3-303(1)

for taxes imposed under Section 31A-3-301.

(iv) The commissioner shall adopt a rule dealing with the payment of stamping fees. If a stamping fee is not paid when due, the commissioner or advisory organization may impose a penalty of 25% of the stamping fee due, plus 1-1/2% per month from the time of default until full payment of the stamping fee.

[~~(v) A stamping fee relative to a policy covering a risk located partially in this state shall be allocated in the same manner as under Subsection 31A-3-303(4).~~]

(e) The commissioner, representatives of the department, advisory organizations, representatives and members of advisory organizations, authorized insurers, and surplus lines insurers are not liable for damages on account of statements, comments, or recommendations made in good faith in connection with their duties under this Subsection (11)(e) or under Section 31A-15-111.

(f) An examination conducted under this Subsection (11) and a document or materials related to the examination are confidential.

(12) (a) For a surplus lines insurance transaction in the state entered into on or after May 13, 2014, if an audit is required by the surplus lines insurance policy, a surplus lines insurer:

(i) shall exercise due diligence to initiate an audit of an insured, to determine whether additional premium is owed by the insured, by no later than six months after the expiration of the term for which premium is paid; and

(ii) may not audit an insured more than three years after the surplus lines insurance policy expires.

(b) A surplus lines insurer that does not comply with this Subsection (12) may not charge or collect additional premium in excess of the premium agreed to under the surplus lines insurance policy.

Section 19. Section **31A-16-103** is amended to read:

31A-16-103. Acquisition of control of, divestiture of control of, or merger with domestic insurer.

(1) (a) A person may not take the actions described in Subsection (1)(b) or (c) unless, at the time any offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of securities if no offer or agreement is involved:

(i) the person files with the commissioner a statement containing the information required by this section;

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

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

(b) Unless the person complies with Subsection (1)(a), a person other than the issuer may not make a tender offer for, a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise, any voting security of a domestic insurer if after the acquisition, the person would directly, indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.

(c) Unless the person complies with Subsection (1)(a), a person may not enter into an agreement to merge with or otherwise to acquire control of:

(i) a domestic insurer; or

(ii) any person controlling a domestic insurer.

(d) For purposes of this section, a controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days before the cessation of control. The commissioner shall determine those instances in which the one or more persons seeking to divest or to acquire a controlling interest in an insurer, will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in the commissioner's discretion, determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in Subsection (1)(a) is otherwise filed, this Subsection (1)(d) does not apply.

(e) With respect to a transaction subject to this section, the acquiring person shall also file a pre-acquisition notification with the commissioner, which shall contain the information set forth in Section 31A-16-104.5. A failure to file the notification may be subject to penalties specified in Section 31A-16-104.5.

(f) (i) For purposes of this section, a domestic insurer includes any person controlling a domestic insurer unless the person as determined by the commissioner is either directly or through its affiliates primarily engaged in business other than the business of insurance.

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

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

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

(B) any person that controls an insurance company.

(iv) This section applies to all domestic insurers and other entities licensed under:

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

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

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

(D) Chapter 9, Insurance Fraternals; and

(E) Chapter 11, Motor Clubs.

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

(A) is in writing; and

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

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

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

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

(i) if the person is an individual:

(A) the person's principal occupation;

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

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

(ii) if the person is not an individual:

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

(I) the past five years; or

(II) for any lesser period as the person and any of its predecessors has been in existence;

(B) an informative description of the business intended to be done by the person and the person's subsidiaries;

(C) a list of all individuals who are or who have been selected to become directors or executive officers of the person, or individuals who perform, or who will perform functions appropriate to such positions; and

(D) for each individual described in Subsection (2)(a)(ii)(C), the information required by Subsection (2)(a)(i) for each individual;

(b) (i) the source, nature, and amount of the consideration used or to be used in effecting the merger or acquisition of control;

(ii) a description of any transaction in which funds were or are to be obtained for the purpose of effecting the merger or acquisition of control, including any pledge of:

(A) the insurer's stock; or

(B) the stock of any of the insurer's subsidiaries or controlling affiliates; and

(iii) the identity of persons furnishing the consideration;

(c) (i) fully audited financial information, or other financial information considered acceptable by the commissioner, of the earnings and financial condition of each acquiring party for:

(A) the preceding five fiscal years of each acquiring party; or

(B) any lesser period the acquiring party and any of its predecessors shall have been in existence; and

(ii) unaudited information:

(A) similar to the information described in Subsection (2)(c)(i); and

(B) prepared within the 90 days prior to the filing of the statement;

(d) any plans or proposals which each acquiring party may have to:

(i) liquidate the insurer;

(ii) sell its assets;

(iii) merge or consolidate the insurer with any person; or

(iv) make any other material change in the insurer's:

(A) business;

(B) corporate structure; or

(C) management;

(e) (i) the number of shares of any security referred to in Subsection (1) that each acquiring party proposes to acquire;

(ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in Subsection (1); and

(iii) a statement as to the method by which the fairness of the proposal was arrived at;

(f) the amount of each class of any security referred to in Subsection (1) that:

(i) is beneficially owned; or

(ii) concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) a full description of any contract, arrangement, or understanding with respect to any security referred to in Subsection (1) in which any acquiring party is involved, including:

(i) the transfer of any of the securities;

(ii) joint ventures;

(iii) loan or option arrangements;

(iv) puts or calls;

(v) guarantees of loans;

(vi) guarantees against loss or guarantees of profits;

(vii) division of losses or profits; or

(viii) the giving or withholding of proxies;

(h) a description of the purchase by any acquiring party of any security referred to in Subsection (1) during the 12 calendar months preceding the filing of the statement including:

(i) the dates of purchase;

(ii) the names of the purchasers; and

(iii) the consideration paid or agreed to be paid for the purchase;

(i) a description of:

(i) any recommendations to purchase by any acquiring party any security referred to in

Subsection (1) made during the 12 calendar months preceding the filing of the statement; or

(ii) any recommendations made by anyone based upon interviews or at the suggestion of the acquiring party;

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

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

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

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

(l) an agreement by the person required to file the statement referred to in Subsection (1) that it will provide the annual report, specified in Section 31A-16-105, for so long as control exists;

(m) an acknowledgment by the person required to file the statement referred to in Subsection (1) that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

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

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

(ii) in the public interest.

(3) The department may request:

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

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

(b) Information obtained by the department from the review of criminal history records

received under Subsection (3)(a) shall be used by the department for the purpose of:

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

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

(iii) preventing persons who violate 18 U.S.C. Sec. 1033 from engaging in the business of insurance in the state.

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

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(a)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(a)(ii); and

(iii) charge the person required to file the statement referred to in Subsection (1) a fee equal to the aggregate of Subsections (3)(c)(i) and (ii).

(4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing the statement so requests.

(b) (i) Under Subsection (2)(e), the commissioner may require a statement of the adjusted book value assigned by the acquiring party to each security in arriving at the terms of the offer.

(ii) For purposes of this Subsection (4)(b), "adjusted book value" means each security's proportional interest in the capital and surplus of the insurer with adjustments that reflect:

(A) market conditions;

(B) business in force; and

(C) other intangible assets or liabilities of the insurer.

(c) The description required by Subsection (2)(g) shall identify the persons with whom the contracts, arrangements, or understandings have been entered into.

(5) (a) If the person required to file the statement referred to in Subsection (1) is a partnership, limited partnership, syndicate, or other group, the commissioner may require that

all the information called for by Subsection (2), (3), or (4) shall be given with respect to each:

(i) partner of the partnership or limited partnership;

(ii) member of the syndicate or group; and

(iii) person who controls the partner or member.

(b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation, or if the person required to file the statement referred to in Subsection (1) is a corporation, the commissioner may require that the information called for by Subsection (2) shall be given with respect to:

(i) the corporation;

(ii) each officer and director of the corporation; and

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

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

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

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

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

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

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

(B) tend to create a monopoly in insurance;

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

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

(B) prejudice the interest of:

(I) its policyholders; or

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

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

(v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its assets, or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are:

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

(B) not in the public interest; or

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

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

(i) are disclosed to the securityholders; and

(ii) determined by the commissioner to be reasonable.

(9) For a merger or other acquisition of control described in Subsection (1), the commissioner:

(a) may hold a public hearing on the merger or other acquisition at the commissioner's discretion; and

(b) shall hold a public hearing on the merger or other acquisition upon request by the acquiring party, the insurer, or any other interested party.

[~~(9)~~] (10) (a) The commissioner shall hold a public hearing [~~referred to in Subsection (8) shall be held within 30~~] under Subsection (9) no later than 45 days after the day on which the statement required by Subsection (1) is filed.

(b) (i) [~~At~~] The commissioner shall give at least 20 days notice of the hearing [~~shall be~~

~~given by the commissioner~~] to the person filing the statement.

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

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

(A) the insurer; and

(B) any person designated by the commissioner.

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

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

(i) present evidence;

(ii) examine and cross-examine witnesses; and

(iii) offer oral and written arguments.

(e) (i) A person or insurer described in Subsection [~~(9)~~] (10)(d) may conduct discovery proceedings in the same manner as is presently allowed in the district courts of this state.

(ii) All discovery proceedings shall be concluded not later than three days before the commencement of the public hearing.

[~~(10)~~] (11) If the proposed acquisition of control will require the approval of more than one commissioner, the public hearing [~~referred to~~] described in Subsection (9)[~~(a)~~] may be held on a consolidated basis upon request of the person filing the statement referred to in Subsection (1). The person shall file the statement referred to in Subsection (1) with the National Association of Insurance Commissioners within five days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing and shall provide notice to the applicant of the opt-out within 10 days of the receipt of the statement referred to in Subsection (1). A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. The commissioners shall hear and receive evidence. A commissioner may attend a hearing under this Subsection [~~(10)~~] (11) in person or by telecommunication.

[~~(11)~~] (12) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be

required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than 60 days after the date of notification of the change in control submitted pursuant to Subsection (1).

[~~(12)~~] (13) (a) The commissioner may retain technical experts to assist in reviewing all, or a portion of, information filed in connection with a proposed merger or other acquisition of control referred to in Subsection (1).

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

(c) (i) A technical expert employed under Subsection [~~(12)~~] (13)(a) shall present to the commissioner a statement of all expenses incurred by the technical expert in conjunction with the technical expert's review of a proposed merger or other acquisition of control.

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

(A) necessarily incurred; and

(B) approved by the commissioner.

(iii) The acquiring person shall:

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

(B) retain a copy of the consolidated account described in Subsection [~~(12)~~] (13)(c)(iii)(A); and

(C) file with the department as a public record a copy of the consolidated account described in Subsection [~~(12)~~] (13)(c)(iii)(A).

[~~(13)~~] (14) (a) (i) If a domestic insurer proposes to merge into another insurer, any securityholder electing to exercise a right of dissent may file with the insurer a written request for payment of the adjusted book value given in the statement required by Subsection (1) and approved under Subsection (8), in return for the surrender of the security holder's securities.

(ii) The request described in Subsection [~~(13)~~] (14)(a)(i) shall be filed not later than 10 days after the day of the securityholders' meeting where the corporate action is approved.

(b) The dissenting securityholder is entitled to and the insurer is required to pay to the dissenting securityholder the specified value within 60 days of receipt of the dissenting security

holder's security.

(c) Persons electing under this Subsection [~~(13)~~] (14) to receive cash for their securities waive the dissenting shareholder and appraisal rights otherwise applicable under Title 16, Chapter 10a, Part 13, Dissenters' Rights.

(d) (i) This Subsection [~~(13)~~] (14) provides an elective procedure for dissenting securityholders to resolve their objections to the plan of merger.

(ii) This section does not restrict the rights of dissenting securityholders under Title 16, Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this Subsection [~~(13)~~] (14).

[~~(14)~~] (15) (a) All statements, amendments, or other material filed under Subsection (1), and all notices of public hearings held under Subsection (8), shall be mailed by the insurer to its securityholders within five business days after the insurer has received the statements, amendments, other material, or notices.

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

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

[~~(15)~~] (16) This section does not apply to any offer, request, invitation, agreement, or acquisition that the commissioner by order exempts from the requirements of this section as:

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

(b) otherwise not comprehended within the purposes of this section.

[~~(16)~~] (17) The following are violations of this section:

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

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

[~~(17)~~] (18) (a) The courts of this state are vested with jurisdiction over:

(i) a person who:

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

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

(ii) overall actions involving persons described in Subsection [~~(17)~~] (18)(a)(i) arising out of a violation of this section.

(b) A person described in Subsection [~~(17)~~] (18)(a) is considered to have performed acts equivalent to and constituting an appointment of the commissioner by that person, to be that person's lawful agent upon whom may be served all lawful process in any action, suit, or proceeding arising out of a violation of this section.

(c) A copy of a lawful process described in Subsection [~~(17)~~] (18)(b) shall be:

(i) served on the commissioner; and

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

Section 20. Section **31A-22-612** is amended to read:

31A-22-612. Conversion privileges for insured former spouse.

(1) An accident and health insurance policy, which in addition to covering the insured also provides coverage to the spouse of the insured, may not contain a provision for termination of coverage of a spouse covered under the policy, except by entry of a valid decree of divorce, legal separation, or annulment between the parties.

(2) Every policy which contains this type of provision shall provide that upon the entry of the divorce decree the spouse is entitled to have issued an individual policy of accident and health insurance without evidence of insurability, upon application to the company and payment of the appropriate premium. The policy shall provide the coverage being issued which is most nearly similar to the terminated coverage. Probationary or waiting periods in the policy are considered satisfied to the extent the coverage was in force under the prior policy.

(3) When the insurer receives actual notice that the coverage of a spouse is to be terminated because of a divorce, legal separation, or annulment, the insurer shall promptly provide the spouse written notification of the right to obtain individual coverage as provided in Subsection (2), the premium amounts required, and the manner, place, and time in which premiums may be paid. The premium is determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of the persons to be covered and to the type and amount of coverage provided. If the spouse applies and tenders the first monthly premium to the insurer within 30 days after receiving the notice provided by this Subsection

(3), the spouse shall receive individual coverage that commences immediately upon termination of coverage under the insured's policy.

(4) This section does not apply to accident and health insurance policies offered on a group blanket basis or a health benefit plan.

Section 21. Section **31A-22-618.6** is amended to read:

31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit plans.

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

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

(b) at the option of the plan sponsor.

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

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

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

(i) the service area of the insurer; or

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

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

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

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

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

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

(4) (a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a

calendar year may continue to renew the health benefit plan purchased in the small group market.

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

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

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

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular health benefit plan product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing to each plan sponsor, employee, or dependent of a plan sponsor or an employee, at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing to the commissioner, and at least three working days before the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other health benefit plans currently being offered by the insurer in the market or, in the case of a large employer, any other health benefit plans currently being offered in that market; and

(D) in exercising the option to discontinue that health benefit plan and in offering the option of coverage in this section, acts uniformly without regard to the claims experience of a plan sponsor, any health status-related factor relating to any covered participant or beneficiary, or any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing to each plan sponsor, employee, or dependent of a plan sponsor or an employee at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing to the commissioner in each state in which an affected insured individual is known to reside and, at least 30 working days before the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market described in Subsection (5)(e)(i); and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(6) (a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (6)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

(7) For purposes of this section, a reference to "plan sponsor" includes a reference to

the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the health benefit plan is made available by an insurer in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(8) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 22. Section **31A-22-629** is amended to read:

31A-22-629. Adverse benefit determination review process.

(1) As used in this section:

(a) (i) "Adverse benefit determination" means the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or in part, for a benefit.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

(B) denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; or

(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(I) experimental;

(II) investigational; or

(III) not medically necessary or appropriate.

(b) "Independent review" means a process that:

(i) is a voluntary option for the resolution of an adverse benefit determination;

(ii) is conducted at the discretion of the claimant;

(iii) is conducted by an independent review organization designated by the [~~insurer~~] commissioner;

(iv) renders an independent and impartial decision on an adverse benefit determination submitted by an insured; and

(v) may not require the insured to pay a fee for requesting the independent review.

(c) "Independent review organization" means a person, subject to Subsection (6), who conducts an independent external review of adverse determinations.

(d) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.

(e) "Insurer" is as defined in Section 31A-1-301 and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that offers, sells, manages, or administers a health insurance policy or health maintenance organization contract that is subject to this title.

(f) "Internal review" means the process an insurer uses to review an insured's adverse benefit determination before the adverse benefit determination is submitted for independent review.

(2) This section applies generally to health insurance policies, health maintenance organization contracts, and income replacement or disability income policies.

(3) (a) An insured may submit an adverse benefit determination to the insurer.

(b) The insurer shall conduct an internal review of the insured's adverse benefit determination.

(c) An insured who disagrees with the results of an internal review may submit the adverse benefit determination for an independent review if the adverse benefit determination involves:

(i) payment of a claim regarding medical necessity; or

(ii) denial of a claim regarding medical necessity.

(4) The commissioner shall adopt rules that establish minimum standards for:

(a) internal reviews;

(b) independent reviews to ensure independence and impartiality;

(c) the types of adverse benefit determinations that may be submitted to an independent review; and

(d) the timing of the review process, including an expedited review when medically necessary.

(5) Nothing in this section may be construed as:

(a) expanding, extending, or modifying the terms of a policy or contract with respect to benefits or coverage;

(b) permitting an insurer to charge an insured for the internal review of an adverse benefit determination;

(c) restricting the use of arbitration in connection with or subsequent to an independent review; or

(d) altering the legal rights of any party to seek court or other redress in connection with:

(i) an adverse decision resulting from an independent review, except that if the insurer is the party seeking legal redress, the insurer shall pay for the reasonable attorney fees of the insured related to the action and court costs; or

(ii) an adverse benefit determination or other claim that is not eligible for submission to independent review.

(6) (a) An independent review organization in relation to the insurer may not be:

(i) the insurer;

(ii) the health plan;

(iii) the health plan's fiduciary;

(iv) the employer; or

(v) an employee or agent of any one listed in Subsections (6)(a)(i) through (iv).

(b) An independent review organization may not have a material professional, familial, or financial conflict of interest with:

(i) the health plan;

(ii) an officer, director, or management employee of the health plan;

(iii) the enrollee;

(iv) the enrollee's health care provider;

(v) the health care provider's medical group or independent practice association;

(vi) a health care facility where service would be provided; or

(vii) the developer or manufacturer of the service that would be provided.

Section 23. Section **31A-22-701** is amended to read:

31A-22-701. Groups eligible for group or blanket insurance.

(1) As used in this section, "association group" means a lawfully formed association of individuals or business entities that:

(a) purchases insurance on a group basis on behalf of members; and

(b) is formed and maintained in good faith for purposes other than obtaining insurance.

(2) A group accident and health insurance policy may be issued to:

(a) a group:

(i) to which a group life insurance policy may be issued under [~~Sections~~] Section 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-506, or 31A-22-507[~~, and 31A-22-509~~]; and

(ii) that is formed and maintained in good faith for a purpose other than obtaining insurance;

(b) an association group authorized by the commissioner that:

(i) has been actively in existence for at least five years;

(ii) has a constitution and bylaws;

(iii) has a shared or common purpose that is not primarily a business or customer relationship;

(iv) is formed and maintained in good faith for purposes other than obtaining insurance;

(v) does not condition membership in the association group on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(vi) makes accident and health insurance coverage offered through the association group available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member;

(vii) does not make accident and health insurance coverage offered through the association group available other than in connection with a member of the association group; and

(viii) is actuarially sound; or

(c) a group specifically authorized by the commissioner [~~under Section 31A-22-509~~], upon a finding that:

(i) authorization is not contrary to the public interest;

(ii) the group is actuarially sound;

(iii) formation of the proposed group may result in economies of scale in acquisition, administrative, marketing, and brokerage costs;

(iv) the insurance policy, insurance certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to insurance policies that are otherwise available to similar groups;

(v) the group would not present hazards of adverse selection;

(vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided; and

(vii) the group is formed and maintained in good faith for a purpose other than obtaining insurance.

(3) A blanket accident and health insurance policy:

(a) covers a defined class of persons;

(b) may not be offered or underwritten on an individual basis;

(c) shall cover only a group that is:

(i) actuarially sound; and

(ii) formed and maintained in good faith for a purpose other than obtaining insurance; and

(d) may be issued only to:

(i) a common carrier or an operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to the person's travel status;

(ii) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;

(iii) an institution of learning, including a school district, a school jurisdictional unit, or the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering students, teachers, or employees;

(iv) a religious, charitable, recreational, educational, or civic organization, or branch of one of those organizations, as policyholder, covering a group of members or participants as

defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;

(v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;

(vi) a volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;

(vii) a newspaper or other publisher, as policyholder, covering its carriers;

(viii) an association, including a labor union, that has a constitution and bylaws and that is organized in good faith for purposes other than that of obtaining insurance, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; and

(ix) any other class of risks that, in the judgment of the commissioner, may be properly eligible for blanket accident and health insurance.

(4) The judgment of the commissioner may be exercised on the basis of:

(a) individual risks;

(b) a class of risks; or

(c) both Subsections (4)(a) and (b).

Section 24. Section **31A-22-722** is amended to read:

31A-22-722. Utah mini-COBRA benefits for employer group coverage.

(1) An insured may extend the employee's coverage under the current employer's group policy for a period of 12 months, except as provided in [~~Subsections (2) and 31A-22-722.5(4)~~] Subsection (2). The right to extend coverage includes:

(a) voluntary termination;

(b) involuntary termination;

(c) retirement;

(d) death;

(e) divorce or legal separation;

(f) loss of dependent status;

(g) sabbatical;

(h) a disability;

(i) leave of absence; or

(j) reduction of hours.

(2) (a) Notwithstanding Subsection (1), an employee may not extend coverage under the current employer's group insurance policy if the employee:

(i) fails to pay premiums or contributions in accordance with the terms of the insurance policy;

(ii) acquires other group coverage covering all preexisting conditions including maternity, if the coverage exists;

(iii) performs an act or practice that constitutes fraud in connection with the coverage;

(iv) makes an intentional misrepresentation of material fact under the terms of the coverage;

(v) is terminated from employment for gross misconduct;

(vi) is not continuously covered under the current employer's group policy for a period of three months immediately before the termination of the insurance policy due to an event set forth in Subsection (1);

(vii) is eligible for an extension of coverage required by federal law;

(viii) establishes residence outside of this state;

(ix) moves out of the insurer's service area;

(x) is eligible for similar coverage under another group insurance policy; or

(xi) has the employee's coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).

(b) The right to extend coverage under Subsection (1) applies to spouse or dependent coverage, including a surviving spouse or dependents whose coverage under the insurance policy terminates by reason of the death of the employee or member.

(3) (a) The employer shall notify the following in writing of the right to extend group coverage and the payment amounts required for extension of coverage, including the manner, place, and time in which the payments shall be made:

(i) a terminated insured;

(ii) an ex-spouse of an insured; or

(iii) if Subsection (2)(b) applies:

(A) a surviving spouse; and

(B) the guardian of surviving dependents, if different from a surviving spouse.

(b) The notification required in Subsection (3)(a) shall be sent first class mail within 30 days after the termination date of the group coverage to:

(i) the terminated insured's home address as shown on the records of the employer;

(ii) the address of the surviving spouse, if different from the insured's address and if shown on the records of the employer;

(iii) the guardian of any dependents address, if different from the insured's address, and if shown on the records of the employer; and

(iv) the address of the ex-spouse, if shown on the records of the employer.

(4) The insurer shall provide the employee, spouse, or any eligible dependent the opportunity to extend the group coverage at the payment amount stated in Subsection (5) if:

(a) the employer policyholder does not provide the terminated insured the written notification required by Subsection (3)(a); and

(b) the employee or other individual eligible for extension contacts the insurer within 60 days of coverage termination.

(5) (a) A premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.

(b) Except as provided in Subsection (5)(a), an insurer may not charge an insured an additional fee, an additional premium, interest, or any similar charge for electing extended group coverage.

(6) Except as provided in this Subsection (6), coverage extends without interruption for 12 months and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:

(a) elects to extend group coverage within 60 days of losing group coverage; and

(b) tenders the amount required to the employer or insurer.

(7) The insured's coverage may be terminated before 12 months if the terminated insured:

(a) establishes residence outside of this state;

(b) moves out of the insurer's service area;

(c) fails to pay premiums or contributions in accordance with the terms of the insurance policy, including any timeliness requirements;

(d) performs an act or practice that constitutes fraud in connection with the coverage;

(e) makes an intentional misrepresentation of material fact under the terms of the coverage;

(f) becomes eligible for similar coverage under another group insurance policy; or

(g) has the coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).

(8) If the current employer coverage is terminated and the employer replaces coverage with similar coverage under another group insurance policy, without interruption, the terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, may obtain extension of coverage under the replacement group insurance policy:

(a) for the balance of the period the terminated insured would have extended coverage under the replaced group insurance policy; and

(b) if the terminated insured is otherwise eligible for extension of coverage.

(9) An insurer shall require an insured employer to offer to the following individuals an open enrollment period at the same time as other regular employees:

(a) an individual who extends group coverage and is current on payment; and

(b) during the applicable grace period described in Subsection (3) or (4), an individual who is eligible to elect to extend group coverage.

Section 25. Section **31A-23a-107** is amended to read:

31A-23a-107. Character requirements.

An applicant for a license under this chapter shall show to the commissioner that:

(1) the applicant has the intent in good faith, to engage in the type of business that the license applied for would permit;

(2) (a) if a natural person, the applicant is:

(i) competent; and

(ii) trustworthy; or

(b) if the applicant is an agency:

(i) the partners, directors, or principal officers or persons having comparable powers are trustworthy; and

(ii) that it will transact business in such a way that the acts that may only be performed by a licensed producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary are performed exclusively by natural persons who are licensed under this chapter to transact that type of business and designated on the agency's license;

(3) the applicant intends to comply with Section 31A-23a-502; and

(4) if a natural person, the applicant is at least 18 years of age.

Section 26. Section **31A-23a-109** is amended to read:

31A-23a-109. Nonresident jurisdictional agreement.

(1) (a) If a nonresident license applicant has a valid producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary license from the nonresident license applicant's home state or designated home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive the license requirements for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or designated home state at the time the nonresident license applicant applies for a nonresident producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary license;

(B) has submitted the proper request for licensure;

(C) has submitted to the commissioner:

(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state or designated home state; or

(II) a completed uniform application; and

(D) has paid the applicable fees under Section 31A-3-103; and

(ii) the nonresident license applicant's license in the applicant's home state or designated home state is in good standing.

(2) A nonresident applicant applying under Subsection (1) shall in addition to complying with all license requirements for a license under this chapter execute, in a form

acceptable to the commissioner, an agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter related to the applicant's insurance activities in this state, on the basis of:

(a) service of process under Sections 31A-2-309 and 31A-2-310; or

(b) service authorized:

(i) in the Utah Rules of Civil Procedure; or

(ii) under Section 78B-3-206.

(3) The commissioner may verify a producer's licensing status through the producer database maintained by:

(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state solely on the fact that the person does not reside in this state.

Section 27. Section **31A-23a-111** is amended to read:

31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (5);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-23a-113; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may

not be reinstated after the license period in which the license is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) A line of authority issued under this chapter remains in force until:

(a) the qualifications pertaining to a line of authority are no longer met by the licensee; or

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5);

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(iii) lapses under Section 31A-23a-113; or

(iv) is voluntarily surrendered; or

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors.

(5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke:

(A) a license; or

(B) a line of authority;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a line of authority;

(iii) limit in whole or in part:

(A) a license; or

(B) a line of authority;

(iv) deny a license application;

(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

(vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and Subsection (5)(a)(v).

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license or line of authority under Section 31A-23a-104, 31A-23a-105, or 31A-23a-107;

(ii) violates:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person in this state within 60 days after the day on which the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the insurance producer's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) violates an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;

(xi) obtains or attempts to obtain a license through misrepresentation or fraud;

(xii) improperly withholds, misappropriates, or converts money or properties received in the course of doing insurance business;

(xiii) intentionally misrepresents the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) life settlement;

(xiv) is convicted of:

(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;

(xv) admits or is found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere:

(A) uses fraudulent, coercive, or dishonest practices; or

(B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license or other professional or occupational license, or [~~its~~] an equivalent[,] to an insurance license or other professional or occupational license:

(A) denied[,];

(B) suspended[~~, or~~];

(C) revoked [~~in another state, province, district, or territory~~]; or

(D) surrendered to resolve an administrative action;

(xviii) forges another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) improperly uses notes or another reference material to complete an examination for an insurance license;

(xx) knowingly accepts insurance business from an individual who is not licensed;

(xxi) fails to comply with an administrative or court order imposing a child support

obligation;

(xxii) fails to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxiii) violates or permits others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is prohibited from engaging in the business of insurance; or

(xxiv) engages in a method or practice in the conduct of business that endangers the legitimate interests of customers and the public.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

(6) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(7) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in an order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval by the commissioner.

(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

(10) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 28. Section **31A-23a-208** is amended to read:

31A-23a-208. Producer and agency authority in health insurance exchange.

A producer or agency licensed under this chapter, with a line of authority that permits the producer or agency to sell, negotiate, or solicit accident and health insurance, is authorized to sell, negotiate, or solicit qualified health plans offered on [~~an~~] a health insurance exchange [~~that is:~~].

[~~(1) operated in the state; or~~]

[~~(2) operated in the state and certified by the United States Department of Health and Human Services as a:~~]

[~~(a) state-based exchange under PPACA;~~]

[~~(b) a federally facilitated exchange under PPACA; or~~]

[~~(c) a partnership exchange under PPACA.~~]

Section 29. Section **31A-23a-406** is amended to read:

31A-23a-406. Title insurance producer's business.

(1) An individual title insurance producer or agency title insurance producer may do escrow involving real property transactions if all of the following exist:

(a) the individual title insurance producer or agency title insurance producer is licensed with:

(i) the title line of authority; and

(ii) the escrow subline of authority;

(b) the individual title insurance producer or agency title insurance producer is appointed by a title insurer authorized to do business in the state;

(c) the individual title insurance producer or agency title insurance producer issues one or more of the following as part of the transaction:

(i) an owner's policy of title insurance; [~~or~~]

(ii) a lender's policy of title insurance; or

(iii) if the transaction does not involve a transfer of ownership, an endorsement to an owner's or a lender's policy of title insurance.

(d) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow:

(i) is deposited:

(A) in a federally insured financial institution; and

(B) in a trust account that is separate from all other trust account money that is not related to real estate transactions;

(ii) is the property of the one or more persons entitled to the money under the provisions of the escrow; and

(iii) is segregated escrow by escrow in the records of the individual title insurance producer or agency title insurance producer;

(e) earnings on money held in escrow may be paid out of the escrow account to any person in accordance with the conditions of the escrow;

(f) the escrow does not require the individual title insurance producer or agency title insurance producer to hold:

(i) construction money; or

(ii) money held for exchange under Section 1031, Internal Revenue Code; and

(g) the individual title insurance producer or agency title insurance producer shall maintain a physical office in Utah staffed by a person with an escrow subline of authority who processes the escrow.

(2) Notwithstanding Subsection (1), an individual title insurance producer or agency title insurance producer may engage in the escrow business if:

(a) the escrow involves:

(i) a mobile home;

(ii) a grazing right;

(iii) a water right; or

(iv) other personal property authorized by the commissioner; and

(b) the individual title insurance producer or agency title insurance producer complies with this section except for Subsection (1)(c).

(3) Money held in escrow:

(a) is not subject to any debts of the individual title insurance producer or agency title insurance producer;

(b) may only be used to fulfill the terms of the individual escrow under which the money is accepted; and

(c) may not be used until the conditions of the escrow are met.

(4) Assets or property other than escrow money received by an individual title insurance producer or agency title insurance producer in accordance with an escrow shall be maintained in a manner that will:

(a) reasonably preserve and protect the asset or property from loss, theft, or damages; and

(b) otherwise comply with the general duties and responsibilities of a fiduciary or bailee.

(5) (a) A check from the trust account described in Subsection (1)(d) may not be drawn, executed, or dated, or money otherwise disbursed unless the segregated escrow account from which money is to be disbursed contains a sufficient credit balance consisting of collected and cleared money at the time the check is drawn, executed, or dated, or money is otherwise disbursed.

(b) As used in this Subsection (5), money is considered to be "collected and cleared," and may be disbursed as follows:

(i) cash may be disbursed on the same day the cash is deposited;

(ii) a wire transfer may be disbursed on the same day the wire transfer is deposited; and

(iii) the proceeds of one or more of the following financial instruments may be disbursed on the same day the financial instruments are deposited if received from a single party to the real estate transaction and if the aggregate of the financial instruments for the real estate transaction is less than $10,000:

(A) a cashier's check, certified check, or official check that is drawn on an existing account at a federally insured financial institution;

(B) a check drawn on the trust account of a principal broker or associate broker licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the individual title insurance producer or agency title insurance producer has reasonable and prudent grounds to believe sufficient money will be available from the trust account on which the check is drawn at the time of disbursement of proceeds from the individual title insurance producer or agency title insurance producer's escrow account;

(C) a personal check not to exceed $500 per closing; or

(D) a check drawn on the escrow account of another individual title insurance producer or agency title insurance producer, if the individual title insurance producer or agency title insurance producer in the escrow transaction has reasonable and prudent grounds to believe that sufficient money will be available for withdrawal from the account upon which the check is drawn at the time of disbursement of money from the escrow account of the individual title insurance producer or agency title insurance producer in the escrow transaction.

(c) A check or deposit not described in Subsection (5)(b) may be disbursed:

(i) within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

(ii) upon notification from the financial institution to which the money has been deposited that final settlement has occurred on the deposited financial instrument.

(6) An individual title insurance producer or agency title insurance producer shall maintain a record of a receipt or disbursement of escrow money.

(7) An individual title insurance producer or agency title insurance producer shall comply with:

(a) Section 31A-23a-409;

(b) Title 46, Chapter 1, Notaries Public Reform Act; and

(c) any rules adopted by the Title and Escrow Commission, subject to Section 31A-2-404, that govern escrows.

(8) If an individual title insurance producer or agency title insurance producer conducts a search for real estate located in the state, the individual title insurance producer or agency title insurance producer shall conduct a reasonable search of the public records.

Section 30. Section **31A-23b-102** is amended to read:

31A-23b-102. Definitions.

As used in this chapter:

(1) "Enroll" and "enrollment" mean to:

(a) (i) obtain personally identifiable information about an individual; and

(ii) inform an individual about accident and health insurance plans or public programs offered on an exchange;

(b) solicit insurance; or

(c) submit to the exchange:

(i) personally identifiable information about an individual; and

(ii) an individual's selection of a particular accident and health insurance plan or public program offered on the exchange.

[~~(2) (a) "Exchange" means an online marketplace that is certified by the United States Department of Health and Human Services as either a state-based small employer exchange or a federally facilitated individual exchange under PPACA.~~]

[~~(b) "Exchange" does not include an online marketplace for the purchase of health insurance if the online marketplace is not a certified exchange in accordance with Subsection (2)(a).~~]

[~~(3)~~] (2) "Navigator":

(a) means a person who facilitates enrollment in an exchange by offering to assist, or who advertises any services to assist, with:

(i) the selection of and enrollment in a qualified health plan or a public program offered on an exchange; or

(ii) applying for premium subsidies through an exchange; and

(b) includes a person who is an in-person assister or a certified application counselor as described in federal regulations or guidance issued under PPACA.

[~~(4)~~] (3) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

[~~(5)~~] (4) "Public programs" means the state Medicaid program in Title 26, Chapter 18, Medical Assistance Act, and Title 26, Chapter 40, Utah Children's Health Insurance Act.

[~~(6)~~] (5) "Resident" is as defined by rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

[~~(7)~~] (6) "Solicit" [~~is as~~] means the same as that term is defined in Section 31A-23a-102.

Section 31. Section **31A-23b-202.5** is amended to read:

31A-23b-202.5. License types.

(1) A license issued under this chapter shall be issued under the license types described in Subsection (2).

(2) A license type under this chapter shall be a navigator line of authority or a certified application counselor line of authority. A license type is intended to describe the matters to be considered under any education, examination, and training required of an applicant under this chapter.

(3) (a) A navigator line of authority includes the enrollment process as described in Subsection 31A-23b-102[~~(3)~~](2)(a).

(b) (i) A certified application counselor line of authority is limited to providing information and assistance to individuals and employees about public programs and premium subsidies available through the exchange.

(ii) A certified application counselor line of authority does not allow the certified application counselor to assist a person with the selection of or enrollment in a qualified health plan offered on an exchange.

Section 32. Section **31A-23b-204** is amended to read:

31A-23b-204. Character requirements.

An applicant for a license under this chapter shall demonstrate to the commissioner that:

(1) the applicant has the intent, in good faith, to engage in the practice of a navigator as the license would permit;

(2) (a) if a natural person, the applicant is:

(i) competent; and

(ii) trustworthy; or

(b) if the applicant is an agency:

(i) the partners, directors, or principal officers or persons having comparable powers are trustworthy; and

(ii) that it will transact business in a way that the acts that may only be performed by a licensed navigator are performed only by a natural person who is licensed under this chapter, or Chapter 23a, Insurance Marketing-Licensing Producers, Consultants, and Reinsurance Intermediaries;

(3) the applicant intends to comply with the surety bond requirements of Section 31A-23b-207;

(4) if a natural person, the applicant is at least 18 years of age; and

(5) the applicant does not have a conflict of interest as defined by regulations issued under PPACA.

Section 33. Section **31A-23b-205** is amended to read:

31A-23b-205. Examination and training requirements.

(1) The commissioner may require an applicant for a license to pass an examination and complete a training program as a requirement for a license.

(2) The examination described in Subsection (1) shall reasonably relate to:

(a) the duties and functions of a navigator;

(b) requirements for navigators as established by federal regulation under PPACA; and

(c) other requirements that may be established by the commissioner by administrative rule.

(3) The examination may be administered by the commissioner or as otherwise

specified by administrative rule.

(4) The training required by Subsection (1) shall be approved by the commissioner and shall include:

(a) accident and health insurance plans;

(b) qualifications for and enrollment in public programs;

(c) qualifications for and enrollment in premium subsidies;

(d) cultural and linguistic competence;

(e) conflict of interest standards;

(f) exchange functions; and

(g) other requirements that may be adopted by the commissioner by administrative rule.

(5) (a) For the navigator line of authority, the training required by Subsection (1) shall consist of at least 21 credit hours of training before obtaining the license, which shall include[~~:(i) at least two hours of training on defined contribution arrangements and the small employer health insurance exchange; and (ii)~~] the navigator training and certification program developed by the Centers for Medicare and Medicaid Services.

(b) For the certified application counselor line of authority, the training required by Subsection (1) shall consist of at least six hours of training before obtaining a license, which shall include[~~:(i) at least one hour of training on defined contribution arrangements and the small employer health insurance exchange; and(ii)~~] the certified application counselor training and certification program developed by the Centers for Medicare and Medicaid Services.

(6) This section applies only to an applicant who is a natural person.

Section 34. Section **31A-23b-206** is amended to read:

31A-23b-206. Continuing education requirements.

(1) The commissioner shall, by rule, prescribe continuing education requirements for a navigator.

(2) (a) The commissioner may not require a degree from an institution of higher education as part of continuing education.

(b) The commissioner may state a continuing education requirement in terms of hours of instruction received in:

(i) accident and health insurance;

(ii) qualification for and enrollment in public programs;

(iii) qualification for and enrollment in premium subsidies;

(iv) cultural competency;

(v) conflict of interest standards; and

(vi) other exchange functions.

(3) (a) For a navigator line of authority, continuing education requirements shall require:

(i) that a licensee complete 12 credit hours of continuing education for every one-year licensing period;

(ii) that at least two of the 12 credit hours described in Subsection (3)(a)(i) be ethics courses; and

[~~(iii) that at least one of the 12 credit hours described in Subsection (3)(a)(i) be training on defined contribution arrangements and the use of the small employer health insurance exchange; and~~]

[~~(iv)~~] (iii) that a licensee complete the annual navigator training and certification program developed by the Centers for Medicare and Medicaid Services.

(b) For a certified application counselor, the continuing education requirements shall require:

(i) that a licensee complete six credit hours of continuing education for every one-year licensing period;

(ii) that at least two of the six credit hours described in Subsection (3)(b)(i) be on ethics courses; and

[~~(iii) that at least one of the six credit hours described in Subsection (3)(b)(i) be training on defined contribution arrangements and the use of the small employer health insurance exchange; and~~]

[~~(iv)~~] (iii) that a licensee complete the annual certified application counselor training and certification program developed by the Centers for Medicare and Medicaid Services.

(c) An hour of continuing education in accordance with Subsections (3)(a)(i) and (b)(i) may be obtained through:

(i) classroom attendance;

(ii) home study;

(iii) watching a video recording; or

(iv) another method approved by rule.

(d) A licensee may obtain continuing education hours at any time during the one-year license period.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall, by rule, authorize one or more continuing education providers, including a state or national professional producer or consultant associations, to:

(i) offer a qualified program on a geographically accessible basis; and

(ii) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner.

(4) The commissioner shall approve a continuing education provider or a continuing education course that satisfies the requirements of this section.

(5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule establish the procedures for continuing education provider registration and course approval.

(6) This section applies only to a navigator who is a natural person.

(7) A navigator shall keep documentation of completing the continuing education requirements of this section for one year after the end of the one-year licensing period to which the continuing education applies.

Section 35. Section **31A-25-204** is amended to read:

31A-25-204. Character requirements.

Each applicant for a license under this chapter shall show to the commissioner all of the following:

(1) [~~he or it~~] that the applicant has the good faith intent to engage in the type of business the license applied for would permit;

(2) (a) if a natural person, [~~he is~~] that the applicant is:

(i) competent; and

(ii) trustworthy[~~,~~]; or[~~,~~]

(b) if a partnership or corporation, that all the partners, directors, principal officers, or persons having comparable powers are trustworthy; and

(3) if a natural person, [~~he~~] that the applicant is at least 18 years of age.

Section 36. Section **31A-25-206** is amended to read:

31A-25-206. Nonresident jurisdictional agreement.

(1) (a) If a nonresident license applicant has a valid license from the nonresident license applicant's home state or designated home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive any license requirement for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident third party administrator license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or designated home state at the time the nonresident license applicant applies for a nonresident third party administrator license;

(B) has submitted the proper request for licensure;

(C) has submitted to the commissioner:

(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state or designated home state; or

(II) a completed uniform application; and

(D) has paid the applicable fees under Section 31A-3-103;

(ii) the nonresident license applicant's license in the applicant's home state or designated home state is in good standing; and

(iii) the nonresident license applicant's home state or designated home state awards nonresident third party administrator licenses to residents of this state on the same basis as this state awards licenses to residents of that home state or designated home state.

(2) A nonresident applicant shall execute in a form acceptable to the commissioner an agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter related to the applicant's insurance activities in Utah, on the basis of:

(a) service of process under Sections 31A-2-309 and 31A-2-310; or

(b) other service authorized in the Utah Rules of Civil Procedure.

(3) The commissioner may verify the third party administrator's licensing status through the database maintained by:

(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state based solely on the fact that the person does not reside in this state.

Section 37. Section **31A-26-102** is amended to read:

31A-26-102. Definitions.

As used in this chapter, unless expressly provided otherwise:

(1) "Company adjuster" means a person employed by an insurer [~~whose regular duties include insurance adjusting~~], or an entity under common control or ownership with the insurer, who negotiates or settles claims on behalf of the employer.

(2) "Designated home state" means the state or territory of the United States or the District of Columbia:

(a) in which an insurance adjuster does not maintain the adjuster's principal:

(i) place of residence; or

(ii) place of business;

(b) if the resident state, territory, or District of Columbia of the adjuster does not license adjusters for the line of authority sought, the adjuster has qualified for the license as if the person were a resident in the state, territory, or District of Columbia described in Subsection (2)(a), including an applicable:

(i) examination requirement;

(ii) fingerprint background check requirement; and

(iii) continuing education requirement; and

(c) the adjuster has designated the state, territory, or District of Columbia as the designated home state.

(3) "Home state" means:

(a) a state or territory of the United States or the District of Columbia in which an insurance adjuster:

(i) maintains the adjuster's principal:

(A) place of residence; or

(B) place of business; and

(ii) is licensed to act as a resident adjuster; or

(b) if the resident state, territory, or the District of Columbia described in Subsection (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District of Columbia:

(i) in which the adjuster is licensed;

(ii) in which the adjuster is in good standing; and

(iii) that the adjuster has designated as the adjuster's designated home state.

(4) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of one or more insurers.

(5) "Insurance adjusting" or "adjusting" means directing or conducting the investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

(6) "Organization" means a person other than a natural person, and includes a sole proprietorship by which a natural person does business under an assumed name.

(7) "Portable electronics insurance" is as defined in Section 31A-22-1802.

(8) "Public adjuster" means a person required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants under insurance policies.

Section 38. Section **31A-26-205** is amended to read:

31A-26-205. Character requirements.

Each applicant for a license under this chapter shall show to the commissioner that:

(1) [~~he~~] the applicant has the good faith intent to engage in the type of business the license or licenses applied for would permit;

(2) (a) if a natural person, [~~he is~~] the applicant is:

(i) competent; and

(ii) trustworthy[~~,~~]; or[~~ that,~~]

(b) if an organization, all the partners, directors, principal officers, or persons in fact having comparable powers are trustworthy, and that [~~it~~] the applicant will transact business in such a way that all acts that may only be performed by a licensed adjuster are performed exclusively by natural persons who are licensed under this chapter to transact that business and

listed on the organization's license under Section 31A-26-209; and

(3) if a natural person, [~~he~~] the applicant is at least 18 years of age.

Section 39. Section **31A-26-208** is amended to read:

31A-26-208. Nonresident jurisdictional agreement.

(1) (a) If a nonresident license applicant has a valid license from the nonresident license applicant's home state or designated home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive any license requirement for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident adjuster's license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or designated home state at the time the nonresident license applicant applies for a nonresident adjuster license;

(B) has submitted the proper request for licensure;

(C) has submitted to the commissioner:

(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state or designated home state; or

(II) a completed uniform application; and

(D) has paid the applicable fees under Section 31A-3-103;

(ii) the nonresident license applicant's license in the applicant's home state or designated home state is in good standing; and

(iii) the nonresident license applicant's home state or designated home state awards nonresident adjuster licenses to residents of this state on the same basis as this state awards licenses to residents of that home state or designated home state.

(2) A nonresident applicant shall execute in a form acceptable to the commissioner an agreement to be subject to the jurisdiction of the commissioner and courts of this state on any matter related to the adjuster's insurance activities in this state, on the basis of:

(a) service of process under Sections 31A-2-309 and 31A-2-310; or

(b) other service authorized under the Utah Rules of Civil Procedure or Section 78B-3-206.

(3) The commissioner may verify an adjuster's licensing status through the database maintained by:

(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state based solely on the fact that the person does not reside in this state.

Section 40. Section **31A-27a-111** is amended to read:

31A-27a-111. Actions by and against the receiver.

(1) (a) An allegation by the receiver of improper or fraudulent conduct against a person may not be the basis of a defense to the enforcement of a contractual obligation owed to the insurer by a third party.

(b) Notwithstanding Subsection (1)(a), a third party described in this Subsection (1) is not barred by this section from seeking to establish independently as a defense that the conduct is materially and substantially related to the contractual obligation for which enforcement is sought.

(2) (a) Subject to Subsection (2)(b), a prior wrongful or negligent action of any present or former officer, manager, director, trustee, owner, employee, or agent of the insurer may not be asserted as a defense to a claim by the receiver:

(i) under a theory of:

(A) estoppel;

(B) comparative fault;

(C) intervening cause;

(D) proximate cause;

(E) reliance; or

(F) mitigation of damages; or

(ii) otherwise.

(b) Notwithstanding Subsection (2)(a):

(i) the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract; and

(ii) a principal under a surety bond or a surety undertaking is entitled to credit against

any reimbursement obligation to the receiver for the value of any property pledged to secure the reimbursement obligation to the extent that:

(A) the receiver has possession or control of the property; or

(B) the insurer or its agents misappropriated, including commingling, the property.

(c) Evidence of fraud in the inducement is admissible only if it is contained in the records of the insurer.

(3) Action or inaction by an insurance regulatory authority may not be asserted as a defense to a claim by the receiver.

(4) (a) Subject to Subsection (4)(b), a judgment or order entered against an insured or the insurer in contravention of a stay or injunction under this chapter, or at any time by default or collusion, may not be considered as evidence of liability or of the quantum of damages in adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.

(b) Subsection (4)(a) does not apply to an affected guaranty association's claim for amounts paid on a settlement or judgment in pursuit of the affected guaranty association's statutory obligations.

(5) (a) Subject to Subsection (5)(b), the following do not affect the amount that a receiver may recover from a third party, regardless of any provision in an agreement to the contrary:

(i) the insurer's insolvency; or

(ii) the insurer's or receiver's failure to pay all or a portion of an amount or a claim to the third party.

(b) If an agreement between the insurer and a third party requires a payment by the insurer before the insurer may recover from the third party, the amount the receiver may recover from the third party under Subsection (5)(a) is limited to an amount equal to the greater of:

(i) the amount paid by the insurer or by another person on behalf of the insurer to the third party; or

(ii) the amount allowed as a claim for payment under:

(A) an approved report described in Section 31A-27a-608;

(B) an order of the receivership court; or

(C) a plan of rehabilitation.

[~~(5)~~] (6) The receiver may not be considered a governmental entity for the purposes of any state law awarding fees to a litigant who prevails against a governmental entity.

Section 41. Section **31A-27a-608** is amended to read:

31A-27a-608. Liquidator's recommendations to the receivership court.

(1) The liquidator shall, from time to time as determined by the liquidator, present to the receivership court for approval, reports of claims settled or determined by the liquidator under Section 31A-27a-603.

(2) A report required by this section shall include information identifying:

(a) the claim;

(b) the amount of the claim; and

(c) the priority class of the claim.

(3) (a) A claim included in a report described in this section and approved by the receivership court is a liability of the estate.

(b) An insurer's insolvency does not affect the amount of a liability described in Subsection (3)(a), regardless of any provision in an agreement to the contrary.

Section 42. Section **31A-30-210** is amended to read:

31A-30-210. State contract requirements -- Employer default plans.

(1) This section applies to an employer who is required to offer [~~its~~] the employer's employees a health benefit plan as a condition of qualifying for a state contract under:

(a) Section 17B-2a-818.5;

(b) Section 19-1-206;

[~~(c) Subsection 63A-5-205(3);~~]

(c) Subsection 63A-5-205.5;

(d) Section 63C-9-403;

(e) Section 72-6-107.5; and

(f) Section 79-2-404.

(2) An employer described in Subsection (1) shall, when selecting the default plan required in Section 31A-30-204, select a default plan that is "qualified health insurance coverage" as defined in the sections listed in Subsections (1)(a) through (f).

Section 43. Section **31A-43-303** is amended to read:

31A-43-303. Stop-loss insurance disclosure.

A stop-loss insurance contract delivered, issued for delivery, or entered into shall include the disclosure exhibit required by the commissioner through administrative rule, which shall include at least the following information:

(1) the complete costs for the stop-loss contract;

(2) the date on which the insurance takes effect and terminates, including renewability provisions;

(3) the aggregate attachment point and the specific attachment point;

(4) limitations on coverage;

(5) an explanation of monthly accommodation and disclosure about any monthly accommodation features included in the stop-loss contract;

(6) a description of terminal liability funding, including the cost of processing claims before and after the termination of the contract; [~~and~~]

(7) maximum claims liability to the employer[~~.~~]; and

(8) a summary of the policy.

Section 44. Section **31A-45-403** is enacted to read:

31A-45-403. Essential health benefits.

(1) The state designates the state's own essential health benefits and does not accept a federal determination of the essential health benefits under the PPACA.

(2) Subject to Subsections (3) and (4), the commissioner shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that designate the essential health benefits for the state.

(3) Before the commissioner makes rules in accordance with Subsection (2):

(a) the commissioner shall present a summary of the commissioner's planned rules to the Health Reform Task Force; and

(b) the Health Reform Task Force shall recommend whether the commissioner makes rules in accordance with the presented summary.

(4) The essential health benefits plan:

(a) may not include a state mandate if the inclusion of the state mandate would require the state to contribute to premium subsidies under the PPACA; and

(b) may add benefits in addition to the benefits included in a benchmark plan adopted in accordance with this section if the additional benefits are mandated under the PPACA.

Section 45. Section **34A-2-107** is amended to read:

34A-2-107. Appointment of workers' compensation advisory council -- Composition -- Terms of members -- Duties -- Compensation.

(1) The commissioner shall appoint a workers' compensation advisory council composed of:

(a) the following voting members:

(i) five employer representatives; and

(ii) five employee representatives; and

(b) the following nonvoting members:

(i) a representative of the workers' compensation insurance carrier that provides workers' compensation insurance under Section 31A-22-1001;

(ii) a representative of a workers' compensation insurance carrier different from the workers' compensation insurance carrier listed in Subsection (1)(b)(i);

(iii) a representative of health care providers;

(iv) the Utah insurance commissioner or the insurance commissioner's designee; and

(v) the commissioner or the commissioner's designee.

(2) Employers and employees shall consider nominating members of groups who historically may have been excluded from the council, such as women, minorities, and individuals with disabilities.

(3) (a) Except as required by Subsection (3)(b), as terms of current council members expire, the commissioner shall appoint each new member or reappointed member to a two-year term beginning July 1 and ending June 30.

(b) Notwithstanding the requirements of Subsection (3)(a), the commissioner shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of council members are staggered so that approximately half of the council is appointed every two years.

(4) (a) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

(b) The commissioner shall terminate the term of a council member who ceases to be representative as designated by the member's original appointment.

(5) The council shall confer at least quarterly for the purpose of advising the

commission, the division, and the Legislature on:

(a) the Utah workers' compensation and occupational disease laws;

(b) the administration of the laws described in Subsection (5)(a); and

(c) rules related to the laws described in Subsection (5)(a).

(6) Regarding workers' compensation, rehabilitation, and reemployment of employees who acquire a disability because of an industrial injury or occupational disease the council shall:

(a) offer advice on issues requested by:

(i) the commission;

(ii) the division; and

(iii) the Legislature; and

(b) make recommendations to:

(i) the commission; and

(ii) the division.

[~~(7) The council shall study how hospital costs may be reduced for purposes of medical benefits for workers' compensation. By no later than November 30, 2017, the council shall submit, in accordance with Section 68-3-14, a written report to the Business and Labor Interim Committee containing the council's recommendations.~~]

(7) (a) The council shall:

(i) study how to reduce hospital costs for purposes of medical benefits for workers' compensation;

(ii) study hospital billing and payment trends in the state;

(iii) study hospital fee schedules used in other states; and

(iv) collect information from third-party hospital bill review companies in the state or region to identify an average reimbursement rate that represents the approximate rate at which a workers' compensation insurance carrier or self-insured employer should expect to reimburse a hospital for billed hospital fees for covered medical services in the state.

(b) In accordance with Section 68-3-14, the council shall submit a written report to the Business and Labor Interim Committee no later than September 1, 2019, 2020, and 2021. Each written report shall include:

(i) recommendations on how to reduce hospital costs for purposes of medical benefits

for workers' compensation;

(ii) aggregate data on hospital billing and payment trends in the state;

(iii) the results of the council's study of hospital fee schedules from other states; and

(iv) the approximate rate at which a workers' compensation insurance carrier or self-insured employer should expect to reimburse a hospital for billed hospital fees for covered medical services, calculated in accordance with Subsection (7)(a)(iv).

(c) For each report described in Subsection (7)(b), the commission may contract with a third-party expert to assist with the council's duties described in Subsections (7)(a) and (b).

(8) The commissioner or the commissioner's designee shall serve as the chair of the council and call the necessary meetings.

(9) The commission shall provide staff support to the council.

(10) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Section 46. Section **34A-2-705** is amended to read:

34A-2-705. Industrial Accident Restricted Account.

(1) As used in this section:

(a) "Account" means the Industrial Accident Restricted Account created by this section.

(b) "Advisory council" means the state workers' compensation advisory council created under Section 34A-2-107.

(2) There is created in the General Fund a restricted account known as the "Industrial Accident Restricted Account."

(3) (a) The account is funded from:

(i) .5% of the premium income remitted to the state treasurer and credited to the account pursuant to Subsection 59-9-101(2)(c)(iv); and

(ii) amounts deposited under Section 34A-2-1003.

(b) If the balance in the account exceeds $500,000 at the close of a fiscal year, the

excess shall be transferred to the Uninsured Employers' Fund created under Section 34A-2-704.

(4) (a) From money appropriated by the Legislature from the account to the commission and subject to the requirements of this section, the commission may fund:

(i) the activities of the Division of Industrial Accidents described in Section 34A-1-202;

(ii) the activities of the Division of Adjudication described in Section 34A-1-202; [~~and~~]

(iii) the activities of the commission described in Section 34A-2-1005[~~.~~]; and

(iv) the activities of the commission described in Subsection 34A-2-107(7)(c), up to $50,000 for each of the three reports described in Subsection 34A-2-107(7)(b).

(b) The money deposited in the account may not be used for a purpose other than a purpose described in this Subsection (4), including an administrative cost or another activity of the commission unrelated to the account.

(5) (a) Each year before the public hearing required by Subsection 59-9-101(2)(d)(i), the commission shall report to the advisory council regarding:

(i) the commission's budget request to the governor for the next fiscal year related to:

(A) the Division of Industrial Accidents; and

(B) the Division of Adjudication;

(ii) the expenditures of the commission for the fiscal year in which the commission is reporting related to:

(A) the Division of Industrial Accidents; and

(B) the Division of Adjudication;

(iii) revenues generated from the premium assessment under Section 59-9-101 on an admitted insurer writing workers' compensation insurance in this state and on a self-insured employer under Section 34A-2-202; and

(iv) money deposited under Section 34A-2-1003.

(b) The commission shall annually report to the governor and the Legislature regarding:

(i) the use of the money appropriated to the commission under this section;

(ii) revenues generated from the premium assessment under Section 59-9-101 on an admitted insurer writing workers' compensation insurance in this state and on a self-insured

employer under Section 34A-2-202; and

(iii) money deposited under Section 34A-2-1003.

Section 47. Section **63A-5-205** is amended to read:

63A-5-205. Contracting powers of director -- Retainage.

[~~(1) As used in this section:~~]

[~~(a) "Capital developments" means the same as that term is defined in Section 63A-5-104.~~]

[~~(b) "Capital improvements" means the same as that term is defined in Section 63A-5-104.~~]

[~~(c) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:~~]

[~~(i) works at least 30 hours per calendar week; and~~]

[~~(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following 60 days from the date of hire.~~]

[~~(d) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.~~]

[~~(e) "Qualified health insurance coverage" means the same as that term is defined in Section 26-40-115.~~]

[~~(f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.~~]

[~~(2)~~] (1) In accordance with Title 63G, Chapter 6a, Utah Procurement Code, the director may:

(a) subject to [~~Subsections (3) and (4)~~] Section 63A-5-205.5, enter into [~~contracts~~] a contract for any work or professional services [~~which~~] that the division or the State Building Board may do or have done; and

(b) as a condition of any contract for architectural or engineering services, prohibit the architect or engineer from retaining a sales or agent engineer for the necessary design work.

[~~(3) Except as provided in Subsection (4), this Subsection (3) applies to~~]

[~~all design or construction contracts entered into by the division or the State Building Board on or after July 1, 2009, and:~~]

[~~(a) applies to a prime contractor if the prime contract is in the amount of $2,000,000 or greater at the original execution of the contract; and~~]

[~~(b) applies to a subcontractor if the subcontract is in the amount of $1,000,000 or greater at the original execution of the contract.~~]

[~~(4) Subsection (3) does not apply:~~]

[~~(a) if the application of Subsection (3) jeopardizes the receipt of federal funds;~~]

[~~(b) if the contract is a sole source contract;~~]

[~~(c) if the contract is an emergency procurement; or~~]

[~~(d) to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the threshold required by Subsection (3).~~]

[~~(5) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (3) is guilty of an infraction.~~]

[~~(6) (a) A contractor subject to Subsection (3) shall demonstrate to the director that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents.~~]

[~~(b) If a subcontractor of the contractor is subject to Subsection (3), the contractor shall:~~]

[~~(i) place a requirement in the subcontract that the subcontractor shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependants during the duration of the subcontract; and~~]

[~~(ii) certify to the director that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the prime contract.~~]

[~~(c) (i) A contractor who fails to meet the requirements of Subsection (6)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (7).~~]

[~~(ii) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (6)(b).~~]

[~~(iii) A subcontractor who fails to meet the requirements of Subsection (6)(b) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (7).~~]

[~~(iv) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (6)(a).~~]

[~~(7) The division shall adopt administrative rules:~~]

[~~(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;~~]

[~~(b) in coordination with:~~]

[~~(i) the Department of Environmental Quality in accordance with Section 19-1-206;~~]

[~~(ii) the Department of Natural Resources in accordance with Section 79-2-404;~~]

[~~(iii) a public transit district in accordance with Section 17B-2a-818.5;~~]

[~~(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;~~]

[~~(v) the Department of Transportation in accordance with Section 72-6-107.5; and~~]

[~~(vi) the Legislature's Administrative Rules Review Committee; and~~]

[~~(c) that establish:~~]

[~~(i) the requirements and procedures a contractor must follow to demonstrate to the director compliance with Subsections (3) through (10) that shall include:~~]

[~~(A) that a contractor shall demonstrate compliance with Subsection (6)(a) or (b) at the time of the execution of each initial contract described in Subsection (3);~~]

[~~(B) that the contractor's compliance is subject to an audit by the division or the Office of the Legislative Auditor General; and~~]

[~~(C) that the actuarially equivalent determination required for the qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency, which is not more than one year old, regarding the contractor's offer of qualified health coverage from an actuary selected by the contractor or the contractor's insurer, or an underwriter who is responsible for developing the employer group's premium rates;~~]

[~~(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of Subsections (3) through (10), which may include:~~]

[~~(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;~~]

[~~(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;~~]

[~~(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and~~]

[~~(D) monetary penalties which may not exceed 50% of the amount necessary to~~

~~purchase qualified health insurance coverage for an employee and the dependents of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and~~]

[~~(iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health insurance coverage identified in Subsection (1)(e), that is provided by the Department of Health, in accordance with Subsection 26-40-115(2).~~]

[~~(8) (a) In addition to the penalties imposed under Subsection (7)(c), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs that would have been covered by qualified health insurance coverage.~~]

[~~(b) An employer has an affirmative defense to a cause of action under Subsection (8)(a) if:~~]

[~~(i) the employer relied in good faith on a written statement of actuarial equivalency provided by:~~]

[~~(A) an actuary; or~~]

[~~(B) an underwriter who is responsible for developing the employer group's premium rates; or~~]

[~~(ii) the department determines that compliance with this section is not required under the provisions of Subsection (4).~~]

[~~(c) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (8).~~]

[~~(9) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created by Section 26-18-402.~~]

[~~(10) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:~~]

[~~(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6a-1602 or any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and~~]

[~~(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.~~]

[~~(11)~~] (2) The judgment of the director as to the responsibility and qualifications of a bidder is conclusive, except in case of fraud or bad faith.

[~~(12)~~] (3) The division shall make all payments to the contractor for completed work in accordance with the contract and pay the interest specified in the contract on any payments that are late.

[~~(13)~~] (4) If any payment on a contract with a private contractor to do work for the division or the State Building Board is retained or withheld, it shall be retained or withheld and released as provided in Section 13-8-5.

Section 48. Section **63A-5-205.5** is enacted to read:

63A-5-205.5. Health insurance requirements -- Penalties.

(1) As used in this section:

(a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project.

(b) "Change order" means the same as that term is defined in Section 63G-6a-103.

(c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days after the day on which the individual is hired.

(d) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.

(e) "Qualified health insurance coverage" means the same as that term is defined in Section 26-40-115.

(f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

(2) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by the division or the State Building Board on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by the division or State Building Board on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction.

(5) (a) A contractor that is subject to the requirements of this section shall demonstrate to the director that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents by submitting to the director a written statement that:

(i) certifies that the contractor offers qualified health insurance coverage in accordance with Section 26-40-115;

(ii) is from:

(A) an actuary selected by the contractor or the contractor's insurer; or

(B) an underwriter who is responsible for developing the employer group's premium rates; and

(iii) was created within one year before the day on which the statement is submitted.

(b) A contractor that is subject to the requirements of this section shall:

(i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and

(ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that:

(A) certifies that the subcontractor offers qualified health insurance coverage in accordance with Section 26-40-115;

(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an underwriter who is responsible for developing the employer group's premium rates; and

(C) was created within one year before the day on which the contractor obtains the statement.

(c) (i) (A) A contractor that fails to maintain an offer of qualified health insurance coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i).

(ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health insurance coverage described in Subsection (5)(a).

(6) The division shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) a public transit district in accordance with Section 17B-2a-818.5;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) that establish:

(i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including:

(A) that a contractor or subcontractor's compliance with this section is subject to an audit by the division or the Office of the Legislative Auditor General;

(B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and

(C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(b)(ii);

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the commercially equivalent benchmark for the qualified health insurance coverage that is provided by the Department of Health in accordance with Subsection 26-40-115(2).

(7) (a) During the duration of a contract, the division may perform an audit to verify a contractor or subcontractor's compliance with this section.

(b) Upon the division's request, a contractor or subcontractor shall provide the division:

(i) a signed actuarial certification that the coverage the contractor or subcontractor offers is qualified health insurance coverage; or

(ii) all relevant documents and information necessary for the division to determine compliance with this section.

(c) If a contractor or subcontractor provides the documents and information described in Subsection (7)(b)(ii), the Insurance Department shall assist the division in determining if the coverage the contractor or subcontractor offers is qualified health insurance coverage.

(8) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor that intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (8)(a) if:

(A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)(b)(ii); or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (8).

(9) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created by Section 26-18-402.

(10) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under:

(i) Section 63G-6a-1602; or

(ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 49. Section **63C-9-403** is amended to read:

63C-9-403. Contracting power of executive director -- Health insurance coverage.

(1) [~~For purposes of~~] As used in this section:

(a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project.

(b) "Change order" means the same as that term is defined in Section 63G-6a-103.

[~~(a)~~] (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" [~~as defined in Section 34A-2-104~~] who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first of the calendar month following 60 days [~~from the date of hire~~] after the day on which the individual is hired.

[~~(b)~~] (d) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.

[~~(c)~~] (e) "Qualified health insurance coverage" means the same as that term is defined in Section 26-40-115.

[~~(d)~~] (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

[~~(2) (a) Except as provided in Subsection (3), this section applies to a design or construction contract entered into by the board or on behalf of the board on or after July 1, 2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).~~]

[~~(b) (i) A prime contractor is subject to this section if the prime contract is in the amount of $2,000,000 or greater at the original execution of the contract.~~]

[~~(ii) A subcontractor is subject to this section if a subcontract is in the amount of $1,000,000 or greater at the original execution of the contract.~~]

[~~(3) This section does not apply if:~~]

(2) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by the board, or on behalf of the board, on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by the board, or on behalf of the board, on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

[~~(4) (a) This section does not apply to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).~~]

[~~(b)~~] (4) A person [~~who~~] that intentionally uses change orders [~~or~~], contract modifications, or multiple contracts to circumvent the requirements of [~~Subsection (2)~~] this section is guilty of an infraction.

(5) (a) A contractor subject to [~~Subsection (2)~~] the requirements of this section shall demonstrate to the executive director that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract[~~.~~] by submitting to the executive director a

written statement that:

[~~(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor shall:~~]

(i) certifies that the contractor offers qualified health insurance coverage in accordance with Section 26-40-115;

(ii) is from:

(A) an actuary selected by the contractor or the contractor's insurer; or

(B) an underwriter who is responsible for developing the employer group's premium rates; and

(iii) was created within one year before the day on which the statement is submitted.

(b) A contractor that is subject to the requirements of this section shall:

(i) place a requirement in [~~the subcontract that the subcontractor~~] each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and

[~~(ii) certify to the executive director that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the prime contract.~~]

(ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that:

(A) certifies that the subcontractor offers qualified health insurance coverage in accordance with Section 26-40-115;

(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an underwriter who is responsible for developing the employer group's premium rates; and

(C) was created within one year before the day on which the contractor obtains the statement.

(c) (i) (A) A contractor [~~who fails to meet the requirements of~~] that fails to maintain an offer of qualified health insurance coverage as described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to [~~meet~~

~~the requirements of~~] obtain and maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i).

(ii) (A) A subcontractor [~~who fails to meet the requirements of~~] that fails to obtain and maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i) during the duration of the [~~contract~~] subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to [~~meet the requirements of~~] maintain an offer of qualified health insurance coverage described in Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section [~~63A-5-205~~] 63A-5-205.5;

(iv) a public transit district in accordance with Section 17B-2a-818.5;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) that establish:

(i) the requirements and procedures a contractor [~~must~~] and a subcontractor shall follow to demonstrate [~~to the executive director~~] compliance with this section [~~that shall include~~], including:

[~~(A) that a contractor shall demonstrate compliance with Subsection (5)(a) or (b) at the time of the execution of each initial contract described in Subsection (2)(b);~~]

[~~(B) that the contractor's~~]

(A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General; [~~and~~]

[~~(C) that the actuarially equivalent determination required for the qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency, which is no more than one year old, regarding the contractor's offer of qualified health coverage from an actuary~~

~~selected by the contractor or the contractor's insurer, or an underwriter who is responsible for developing the employer group's premium rates;~~]

(B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and

(C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(b)(ii);

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health insurance coverage identified in Subsection (1)[~~(c)~~](e), that is provided by the Department of Health, in accordance with Subsection 26-40-115(2).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section [~~shall be~~] is liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement [~~of actuarial equivalency provided by:~~] described in Subsection (5)(a) or (5)(b)(ii); or

[~~(I) an actuary; or~~]

[~~(II) an underwriter who is responsible for developing the employer group's premium~~

~~rates; or~~]

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3) [~~or (4)~~].

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under:

(i) Section 63G-6a-1602; or

(ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 50. Section **63G-2-305** is amended to read:

63G-2-305. Protected records.

The following records are protected if properly classified by a governmental entity:

(1) trade secrets as defined in Section 13-24-2 if the person submitting the trade secret has provided the governmental entity with the information specified in Section 63G-2-309;

(2) commercial information or nonindividual financial information obtained from a person if:

(a) disclosure of the information could reasonably be expected to result in unfair competitive injury to the person submitting the information or would impair the ability of the governmental entity to obtain necessary information in the future;

(b) the person submitting the information has a greater interest in prohibiting access than the public in obtaining access; and

(c) the person submitting the information has provided the governmental entity with the information specified in Section 63G-2-309;

(3) commercial or financial information acquired or prepared by a governmental entity

to the extent that disclosure would lead to financial speculations in currencies, securities, or commodities that will interfere with a planned transaction by the governmental entity or cause substantial financial injury to the governmental entity or state economy;

(4) records, the disclosure of which could cause commercial injury to, or confer a competitive advantage upon a potential or actual competitor of, a commercial project entity as defined in Subsection 11-13-103(4);

(5) test questions and answers to be used in future license, certification, registration, employment, or academic examinations;

(6) records, the disclosure of which would impair governmental procurement proceedings or give an unfair advantage to any person proposing to enter into a contract or agreement with a governmental entity, except, subject to Subsections (1) and (2), that this Subsection (6) does not restrict the right of a person to have access to, after the contract or grant has been awarded and signed by all parties, a bid, proposal, application, or other information submitted to or by a governmental entity in response to:

(a) an invitation for bids;

(b) a request for proposals;

(c) a request for quotes;

(d) a grant; or

(e) other similar document;

(7) information submitted to or by a governmental entity in response to a request for information, except, subject to Subsections (1) and (2), that this Subsection (7) does not restrict the right of a person to have access to the information, after:

(a) a contract directly relating to the subject of the request for information has been awarded and signed by all parties; or

(b) (i) a final determination is made not to enter into a contract that relates to the subject of the request for information; and

(ii) at least two years have passed after the day on which the request for information is issued;

(8) records that would identify real property or the appraisal or estimated value of real or personal property, including intellectual property, under consideration for public acquisition before any rights to the property are acquired unless:

(a) public interest in obtaining access to the information is greater than or equal to the governmental entity's need to acquire the property on the best terms possible;

(b) the information has already been disclosed to persons not employed by or under a duty of confidentiality to the entity;

(c) in the case of records that would identify property, potential sellers of the described property have already learned of the governmental entity's plans to acquire the property;

(d) in the case of records that would identify the appraisal or estimated value of property, the potential sellers have already learned of the governmental entity's estimated value of the property; or

(e) the property under consideration for public acquisition is a single family residence and the governmental entity seeking to acquire the property has initiated negotiations to acquire the property as required under Section 78B-6-505;

(9) records prepared in contemplation of sale, exchange, lease, rental, or other compensated transaction of real or personal property including intellectual property, which, if disclosed prior to completion of the transaction, would reveal the appraisal or estimated value of the subject property, unless:

(a) the public interest in access is greater than or equal to the interests in restricting access, including the governmental entity's interest in maximizing the financial benefit of the transaction; or

(b) when prepared by or on behalf of a governmental entity, appraisals or estimates of the value of the subject property have already been disclosed to persons not employed by or under a duty of confidentiality to the entity;

(10) records created or maintained for civil, criminal, or administrative enforcement purposes or audit purposes, or for discipline, licensing, certification, or registration purposes, if release of the records:

(a) reasonably could be expected to interfere with investigations undertaken for enforcement, discipline, licensing, certification, or registration purposes;

(b) reasonably could be expected to interfere with audits, disciplinary, or enforcement proceedings;

(c) would create a danger of depriving a person of a right to a fair trial or impartial hearing;

(d) reasonably could be expected to disclose the identity of a source who is not generally known outside of government and, in the case of a record compiled in the course of an investigation, disclose information furnished by a source not generally known outside of government if disclosure would compromise the source; or

(e) reasonably could be expected to disclose investigative or audit techniques, procedures, policies, or orders not generally known outside of government if disclosure would interfere with enforcement or audit efforts;

(11) records the disclosure of which would jeopardize the life or safety of an individual;

(12) records the disclosure of which would jeopardize the security of governmental property, governmental programs, or governmental recordkeeping systems from damage, theft, or other appropriation or use contrary to law or public policy;

(13) records that, if disclosed, would jeopardize the security or safety of a correctional facility, or records relating to incarceration, treatment, probation, or parole, that would interfere with the control and supervision of an offender's incarceration, treatment, probation, or parole;

(14) records that, if disclosed, would reveal recommendations made to the Board of Pardons and Parole by an employee of or contractor for the Department of Corrections, the Board of Pardons and Parole, or the Department of Human Services that are based on the employee's or contractor's supervision, diagnosis, or treatment of any person within the board's jurisdiction;

(15) records and audit workpapers that identify audit, collection, and operational procedures and methods used by the State Tax Commission, if disclosure would interfere with audits or collections;

(16) records of a governmental audit agency relating to an ongoing or planned audit until the final audit is released;

(17) records that are subject to the attorney client privilege;

(18) records prepared for or by an attorney, consultant, surety, indemnitor, insurer, employee, or agent of a governmental entity for, or in anticipation of, litigation or a judicial, quasi-judicial, or administrative proceeding;

(19) (a) (i) personal files of a state legislator, including personal correspondence to or from a member of the Legislature; and

(ii) notwithstanding Subsection (19)(a)(i), correspondence that gives notice of legislative action or policy may not be classified as protected under this section; and

(b) (i) an internal communication that is part of the deliberative process in connection with the preparation of legislation between:

(A) members of a legislative body;

(B) a member of a legislative body and a member of the legislative body's staff; or

(C) members of a legislative body's staff; and

(ii) notwithstanding Subsection (19)(b)(i), a communication that gives notice of legislative action or policy may not be classified as protected under this section;

(20) (a) records in the custody or control of the Office of Legislative Research and General Counsel, that, if disclosed, would reveal a particular legislator's contemplated legislation or contemplated course of action before the legislator has elected to support the legislation or course of action, or made the legislation or course of action public; and

(b) notwithstanding Subsection (20)(a), the form to request legislation submitted to the Office of Legislative Research and General Counsel is a public document unless a legislator asks that the records requesting the legislation be maintained as protected records until such time as the legislator elects to make the legislation or course of action public;

(21) research requests from legislators to the Office of Legislative Research and General Counsel or the Office of the Legislative Fiscal Analyst and research findings prepared in response to these requests;

(22) drafts, unless otherwise classified as public;

(23) records concerning a governmental entity's strategy about:

(a) collective bargaining; or

(b) imminent or pending litigation;

(24) records of investigations of loss occurrences and analyses of loss occurrences that may be covered by the Risk Management Fund, the Employers' Reinsurance Fund, the Uninsured Employers' Fund, or similar divisions in other governmental entities;

(25) records, other than personnel evaluations, that contain a personal recommendation concerning an individual if disclosure would constitute a clearly unwarranted invasion of personal privacy, or disclosure is not in the public interest;

(26) records that reveal the location of historic, prehistoric, paleontological, or

biological resources that if known would jeopardize the security of those resources or of valuable historic, scientific, educational, or cultural information;

(27) records of independent state agencies if the disclosure of the records would conflict with the fiduciary obligations of the agency;

(28) records of an institution within the state system of higher education defined in Section 53B-1-102 regarding tenure evaluations, appointments, applications for admissions, retention decisions, and promotions, which could be properly discussed in a meeting closed in accordance with Title 52, Chapter 4, Open and Public Meetings Act, provided that records of the final decisions about tenure, appointments, retention, promotions, or those students admitted, may not be classified as protected under this section;

(29) records of the governor's office, including budget recommendations, legislative proposals, and policy statements, that if disclosed would reveal the governor's contemplated policies or contemplated courses of action before the governor has implemented or rejected those policies or courses of action or made them public;

(30) records of the Office of the Legislative Fiscal Analyst relating to budget analysis, revenue estimates, and fiscal notes of proposed legislation before issuance of the final recommendations in these areas;

(31) records provided by the United States or by a government entity outside the state that are given to the governmental entity with a requirement that they be managed as protected records if the providing entity certifies that the record would not be subject to public disclosure if retained by it;

(32) transcripts, minutes, or reports of the closed portion of a meeting of a public body except as provided in Section 52-4-206;

(33) records that would reveal the contents of settlement negotiations but not including final settlements or empirical data to the extent that they are not otherwise exempt from disclosure;

(34) memoranda prepared by staff and used in the decision-making process by an administrative law judge, a member of the Board of Pardons and Parole, or a member of any other body charged by law with performing a quasi-judicial function;

(35) records that would reveal negotiations regarding assistance or incentives offered by or requested from a governmental entity for the purpose of encouraging a person to expand

or locate a business in Utah, but only if disclosure would result in actual economic harm to the person or place the governmental entity at a competitive disadvantage, but this section may not be used to restrict access to a record evidencing a final contract;

(36) materials to which access must be limited for purposes of securing or maintaining the governmental entity's proprietary protection of intellectual property rights including patents, copyrights, and trade secrets;

(37) the name of a donor or a prospective donor to a governmental entity, including an institution within the state system of higher education defined in Section 53B-1-102, and other information concerning the donation that could reasonably be expected to reveal the identity of the donor, provided that:

(a) the donor requests anonymity in writing;

(b) any terms, conditions, restrictions, or privileges relating to the donation may not be classified protected by the governmental entity under this Subsection (37); and

(c) except for an institution within the state system of higher education defined in Section 53B-1-102, the governmental unit to which the donation is made is primarily engaged in educational, charitable, or artistic endeavors, and has no regulatory or legislative authority over the donor, a member of the donor's immediate family, or any entity owned or controlled by the donor or the donor's immediate family;

(38) accident reports, except as provided in Sections 41-6a-404, 41-12a-202, and 73-18-13;

(39) a notification of workers' compensation insurance coverage described in Section 34A-2-205;

(40) (a) the following records of an institution within the state system of higher education defined in Section 53B-1-102, which have been developed, discovered, disclosed to, or received by or on behalf of faculty, staff, employees, or students of the institution:

(i) unpublished lecture notes;

(ii) unpublished notes, data, and information:

(A) relating to research; and

(B) of:

(I) the institution within the state system of higher education defined in Section 53B-1-102; or

(II) a sponsor of sponsored research;

(iii) unpublished manuscripts;

(iv) creative works in process;

(v) scholarly correspondence; and

(vi) confidential information contained in research proposals;

(b) Subsection (40)(a) may not be construed to prohibit disclosure of public information required pursuant to Subsection 53B-16-302(2)(a) or (b); and

(c) Subsection (40)(a) may not be construed to affect the ownership of a record;

(41) (a) records in the custody or control of the Office of Legislative Auditor General that would reveal the name of a particular legislator who requests a legislative audit prior to the date that audit is completed and made public; and

(b) notwithstanding Subsection (41)(a), a request for a legislative audit submitted to the Office of the Legislative Auditor General is a public document unless the legislator asks that the records in the custody or control of the Office of Legislative Auditor General that would reveal the name of a particular legislator who requests a legislative audit be maintained as protected records until the audit is completed and made public;

(42) records that provide detail as to the location of an explosive, including a map or other document that indicates the location of:

(a) a production facility; or

(b) a magazine;

(43) information:

(a) contained in the statewide database of the Division of Aging and Adult Services created by Section 62A-3-311.1; or

(b) received or maintained in relation to the Identity Theft Reporting Information System (IRIS) established under Section 67-5-22;

(44) information contained in the Management Information System and Licensing Information System described in Title 62A, Chapter 4a, Child and Family Services;

(45) information regarding National Guard operations or activities in support of the National Guard's federal mission;

(46) records provided by any pawn or secondhand business to a law enforcement agency or to the central database in compliance with Title 13, Chapter 32a, Pawnshop and

Secondhand Merchandise Transaction Information Act;

(47) information regarding food security, risk, and vulnerability assessments performed by the Department of Agriculture and Food;

(48) except to the extent that the record is exempt from this chapter pursuant to Section 63G-2-106, records related to an emergency plan or program, a copy of which is provided to or prepared or maintained by the Division of Emergency Management, and the disclosure of which would jeopardize:

(a) the safety of the general public; or

(b) the security of:

(i) governmental property;

(ii) governmental programs; or

(iii) the property of a private person who provides the Division of Emergency Management information;

(49) records of the Department of Agriculture and Food that provides for the identification, tracing, or control of livestock diseases, including any program established under Title 4, Chapter 24, Utah Livestock Brand and Anti-Theft Act, or Title 4, Chapter 31, Control of Animal Disease;

(50) as provided in Section 26-39-501:

(a) information or records held by the Department of Health related to a complaint regarding a child care program or residential child care which the department is unable to substantiate; and

(b) information or records related to a complaint received by the Department of Health from an anonymous complainant regarding a child care program or residential child care;

(51) unless otherwise classified as public under Section 63G-2-301 and except as provided under Section 41-1a-116, an individual's home address, home telephone number, or personal mobile phone number, if:

(a) the individual is required to provide the information in order to comply with a law, ordinance, rule, or order of a government entity; and

(b) the subject of the record has a reasonable expectation that this information will be kept confidential due to:

(i) the nature of the law, ordinance, rule, or order; and

(ii) the individual complying with the law, ordinance, rule, or order;

(52) the name, home address, work addresses, and telephone numbers of an individual that is engaged in, or that provides goods or services for, medical or scientific research that is:

(a) conducted within the state system of higher education, as defined in Section 53B-1-102; and

(b) conducted using animals;

(53) an initial proposal under Title 63N, Chapter 13, Part 2, Government Procurement Private Proposal Program, to the extent not made public by rules made under that chapter;

(54) in accordance with Section 78A-12-203, any record of the Judicial Performance Evaluation Commission concerning an individual commissioner's vote on whether or not to recommend that the voters retain a judge including information disclosed under Subsection 78A-12-203(5)(e);

(55) information collected and a report prepared by the Judicial Performance Evaluation Commission concerning a judge, unless Section 20A-7-702 or Title 78A, Chapter 12, Judicial Performance Evaluation Commission Act, requires disclosure of, or makes public, the information or report;

(56) records contained in the Management Information System created in Section 62A-4a-1003;

(57) records provided or received by the Public Lands Policy Coordinating Office in furtherance of any contract or other agreement made in accordance with Section 63J-4-603;

(58) information requested by and provided to the 911 Division under Section 63H-7a-302;

(59) in accordance with Section 73-10-33:

(a) a management plan for a water conveyance facility in the possession of the Division of Water Resources or the Board of Water Resources; or

(b) an outline of an emergency response plan in possession of the state or a county or municipality;

(60) the following records in the custody or control of the Office of Inspector General of Medicaid Services, created in Section 63A-13-201:

(a) records that would disclose information relating to allegations of personal misconduct, gross mismanagement, or illegal activity of a person if the information or

allegation cannot be corroborated by the Office of Inspector General of Medicaid Services through other documents or evidence, and the records relating to the allegation are not relied upon by the Office of Inspector General of Medicaid Services in preparing a final investigation report or final audit report;

(b) records and audit workpapers to the extent they would disclose the identity of a person who, during the course of an investigation or audit, communicated the existence of any Medicaid fraud, waste, or abuse, or a violation or suspected violation of a law, rule, or regulation adopted under the laws of this state, a political subdivision of the state, or any recognized entity of the United States, if the information was disclosed on the condition that the identity of the person be protected;

(c) before the time that an investigation or audit is completed and the final investigation or final audit report is released, records or drafts circulated to a person who is not an employee or head of a governmental entity for the person's response or information;

(d) records that would disclose an outline or part of any investigation, audit survey plan, or audit program; or

(e) requests for an investigation or audit, if disclosure would risk circumvention of an investigation or audit;

(61) records that reveal methods used by the Office of Inspector General of Medicaid Services, the fraud unit, or the Department of Health, to discover Medicaid fraud, waste, or abuse;

(62) information provided to the Department of Health or the Division of Occupational and Professional Licensing under Subsection 58-68-304(3) or (4);

(63) a record described in Section 63G-12-210;

(64) captured plate data that is obtained through an automatic license plate reader system used by a governmental entity as authorized in Section 41-6a-2003;

(65) any record in the custody of the Utah Office for Victims of Crime relating to a victim, including:

(a) a victim's application or request for benefits;

(b) a victim's receipt or denial of benefits; and

(c) any administrative notes or records made or created for the purpose of, or used to, evaluate or communicate a victim's eligibility for or denial of benefits from the Crime Victim

Reparations Fund;

(66) an audio or video recording created by a body-worn camera, as that term is defined in Section 77-7a-103, that records sound or images inside a hospital or health care facility as those terms are defined in Section 78B-3-403, inside a clinic of a health care provider, as that term is defined in Section 78B-3-403, or inside a human service program as that term is defined in Subsection 62A-2-101(19)(a)(vi), except for recordings that:

(a) depict the commission of an alleged crime;

(b) record any encounter between a law enforcement officer and a person that results in death or bodily injury, or includes an instance when an officer fires a weapon;

(c) record any encounter that is the subject of a complaint or a legal proceeding against a law enforcement officer or law enforcement agency;

(d) contain an officer involved critical incident as defined in Subsection 76-2-408(1)(d); or

(e) have been requested for reclassification as a public record by a subject or authorized agent of a subject featured in the recording; [~~and~~]

(67) a record pertaining to the search process for a president of an institution of higher education described in Section 53B-2-102, except for application materials for a publicly announced finalist[~~.~~]; and

(68) work papers as defined in Section 31A-2-204.

Section 51. Section **72-6-107.5** is amended to read:

72-6-107.5. Construction of improvements of highway -- Contracts -- Health insurance coverage.

(1) [~~For purposes of~~] As used in this section:

(a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project.

(b) "Change order" means the same as that term is defined in Section 63G-6a-103.

[~~(a)~~] (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" [~~as defined in Section 34A-2-104~~] who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days [~~from the date of hire~~]

after the day on which the individual is hired.

[~~(b)~~] (d) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.

[~~(c)~~] (e) "Qualified health insurance coverage" means the same as that term is defined in Section 26-40-115.

[~~(d)~~] (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

[~~(2) (a) Except as provided in Subsection (3), this section applies to contracts entered into by the department on or after July 1, 2009, for construction or design of highways and to a prime contractor or to a subcontractor in accordance with Subsection (2)(b).~~]

[~~(b) (i) A prime contractor is subject to this section if the prime contract is in the amount of $2,000,000 or greater at the original execution of the contract.~~]

[~~(ii) A subcontractor is subject to this section if a subcontract is in the amount of $1,000,000 or greater at the original execution of the contract.~~]

[~~(3) This section does not apply if:~~]

(2) (a) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by the department on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

[~~(4) (a) This section does not apply to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).~~]

[~~(b)~~] (4) A person [~~who~~] that intentionally uses change orders [~~or~~], contract modifications, or multiple contracts to circumvent the requirements of [~~Subsection (2)~~] this

section is guilty of an infraction.

(5) (a) A contractor subject to [~~Subsection (2)~~] the requirements of this section shall demonstrate to the department that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract[~~.~~] by submitting to the department a written statement that:

[~~(b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall:~~]

(i) certifies that the contractor offers qualified health insurance coverage in accordance with Section 26-40-115;

(ii) is from:

(A) an actuary selected by the contractor or the contractor's insurer; or

(B) an underwriter who is responsible for developing the employer group's premium rates; and

(iii) was created within one year before the day on which the statement is submitted.

(b) A contractor that is subject to the requirements of this section shall:

(i) place a requirement in [~~the subcontract that the subcontractor~~] each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and

[~~(ii) certify to the department that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the prime contract.~~]

(ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that:

(A) certifies that the subcontractor offers qualified health insurance coverage in accordance with Section 26-40-115;

(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an underwriter who is responsible for developing the employer group's premium rates; and

(C) was created within one year before the day on which the contractor obtains the statement.

(c) (i) (A) A contractor [~~who fails to meet the requirements of~~] that fails to maintain an

offer of qualified health insurance coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to [~~meet the requirements of~~] obtain and maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i).

(ii) (A) A subcontractor [~~who fails to meet the requirements of~~] that fails to obtain and maintain an offer of qualified health insurance coverage described in Subsection (5)(b) during the duration of the [~~contract~~] subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to [~~meet the requirements of~~] maintain an offer of qualified health insurance coverage described in Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section [~~63A-5-205~~] 63A-5-205.5;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) a public transit district in accordance with Section 17B-2a-818.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) that establish:

(i) the requirements and procedures a contractor [~~must~~] and a subcontractor shall follow to demonstrate [~~to the department~~] compliance with this section [~~that shall include~~], including:

[~~(A) that a contractor shall demonstrate compliance with Subsection (5)(a) or (b) at the time of the execution of each initial contract described in Subsection (2)(b);~~]

[~~(B) that the contractor's~~]

(A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General; [~~and~~]

[~~(C) that the actuarially equivalent determination required for qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency, which is no more than one year old, regarding the contractor's offer of qualified health coverage from an actuary selected by the contractor or the contractor's insurer, or an underwriter who is responsible for developing the employer group's premium rates;~~]

(B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and

(C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(b)(ii);

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and a dependent of the employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health insurance coverage identified in Subsection (1)[~~(c)~~](e), that is provided by the Department of Health, in accordance with Subsection 26-40-115(2).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section [~~shall be~~] is liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement [~~of actuarial equivalency provided by:~~] described in Subsection (5)(a) or (5)(b)(ii); or

[~~(I) an actuary; or~~]

[~~(II) an underwriter who is responsible for developing the employer group's premium rates; or~~]

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3) [~~or (4)~~].

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under:

(i) Section 63G-6a-1602; or

(ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 52. Section **79-2-404** is amended to read:

79-2-404. Contracting powers of department -- Health insurance coverage.

(1) [~~For purposes of~~] As used in this section:

(a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project.

(b) "Change order" means the same as that term is defined in Section 63G-6a-103.

[~~(a)~~] (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" [~~as defined in Section 34A-2-104~~] who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days [~~from the date of hire~~]

after the day on which the individual is hired.

[~~(b)~~] (d) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.

[~~(c)~~] (e) "Qualified health insurance coverage" means the same as that term is defined in Section 26-40-115.

[~~(d)~~] (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

[~~(2) (a) Except as provided in Subsection (3), this section applies a design or construction contract entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, and to a prime contractor or to a subcontractor in accordance with Subsection (2)(b).~~]

[~~(b) (i) A prime contractor is subject to this section if the prime contract is in the amount of $2,000,000 or greater at the original execution of the contract.~~]

[~~(ii) A subcontractor is subject to this section if a subcontract is in the amount of $1,000,000 or greater at the original execution of the contract.~~]

(2) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) This section does not apply to contracts entered into by the department or a division, board, or council of the department if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract or agreement is between:

(i) the department or a division, board, or council of the department; and

(ii) (A) another agency of the state;

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state; or

(c) the contract or agreement is:

(i) for the purpose of disbursing grants or loans authorized by statute;

(ii) a sole source contract; or

(iii) an emergency procurement.

[~~(4) (a) This section does not apply to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).~~]

[~~(b)~~] (4) A person [~~who~~] that intentionally uses change orders [~~or~~], contract modifications, or multiple contracts to circumvent the requirements of [~~Subsection (2)~~] this section is guilty of an infraction.

(5) (a) A contractor subject to [~~Subsection (2)(b)(i)~~] the requirements of this section shall demonstrate to the department that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract[~~.~~] by submitting to the department a written statement that:

[~~(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor shall:~~]

(i) certifies that the contractor offers qualified health insurance coverage in accordance with Section 26-40-115;

(ii) is from:

(A) an actuary selected by the contractor or the contractor's insurer; or

(B) an underwriter who is responsible for developing the employer group's premium rates; and

(iii) was created within one year before the day on which the statement is submitted.

(b) A contractor that is subject to the requirements of this section shall:

(i) place a requirement in [~~the subcontract that the subcontractor~~] each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' [~~dependants~~] dependents during the duration of the subcontract; and

[~~(ii) certify to the department that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the prime contract.~~]

(ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that:

(A) certifies that the subcontractor offers qualified health insurance coverage in accordance with Section 26-40-115;

(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, or an underwriter who is responsible for developing the employer group's premium rates; and

(C) was created within one year before the day on which the contractor obtains the statement.

(c) (i) (A) A contractor [~~who fails to meet the requirements of~~] that fails to maintain an offer of qualified health insurance coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to [~~meet the requirements of~~] obtain and maintain an offer of qualified health insurance coverage described in Subsection (5)(b)(i).

(ii) (A) A subcontractor [~~who fails to meet the requirements of~~] that fails to obtain and maintain an offer of qualified health insurance coverage described in Subsection (5)(b) during the duration of the [~~contract~~] subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to [~~meet the requirements of~~] maintain an offer of qualified health insurance coverage described in Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) a public transit district in accordance with Section 17B-2a-818.5;

(iii) the State Building Board in accordance with Section [~~63A-5-205~~] 63A-5-205.5;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) that establish:

(i) the requirements and procedures a contractor [~~must~~] and a subcontractor shall follow to demonstrate compliance with this section [~~to the department that shall include~~], including:

[~~(A) that a contractor shall demonstrate compliance with Subsection (5)(a) or (b) at the time of the execution of each initial contract described in Subsection (2)(b);~~]

[~~(B) that the contractor's~~]

(A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General; [~~and~~]

[~~(C) that the actuarially equivalent determination required for qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency, which is no more than one year old, regarding the contractor's offer of qualified health coverage from an actuary selected by the contractor or the contractor's insurer, or an underwriter who is responsible for developing the employer group's premium rates;~~]

(B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and

(C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(b)(ii);

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to

purchase qualified health insurance coverage for an employee and a dependent of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health insurance coverage identified in Subsection (1)[~~(c)~~](e), provided by the Department of Health, in accordance with Subsection 26-40-115(2).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section [~~shall be~~] is liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement [~~of actuarial equivalency provided by:~~] described in Subsection (5)(a) or (5)(b)(ii); or

[~~(I) an actuary; or~~]

[~~(II) an underwriter who is responsible for developing the employer group's premium rates; or~~]

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3) [~~or (4)~~].

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under:

(i) Section 63G-6a-1602; or

(ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design

or construction.

Section 53. **Repealer.**

This bill repeals:

Section **31A-22-722.5, Mini-COBRA election -- American Recovery and Reinvestment Act.**

Section **31A-30-209, Insurance producers and the Health Insurance Exchange.**