

**Representative James A. Dunnigan** proposes the following substitute bill:

**INSURANCE AMENDMENTS**

2020 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: James A. Dunnigan**

Senate Sponsor: Curtis S. Bramble

---

---

**LONG TITLE**

**General Description:**

This bill amends and enacts provisions under the Insurance Code and related to certain health benefit plans.

**Highlighted Provisions:**

This bill:

- ▶ defines terms;
- ▶ amends provisions related to certain contractors and subcontractors and health benefit plans;
- ▶ amends the scope and applicability of the Insurance Code;
- ▶ removes the requirement that the Insurance Department employ a chief examiner;
- ▶ permits a signature of the insurance commissioner to be in a format that affixes an exact copy of the signature;
- ▶ prohibits more than two members of the Title and Escrow Commission to be employees of an entity operating under an affiliated business arrangement;
- ▶ amends requirements for doing business in relation to service contract providers and warrantors;
- ▶ amends provisions regarding required disclosures for a service contract or a vehicle protection product warranty;



- 26           ▶ permits the insurance commissioner to exempt a health maintenance organization  
27 from certain deposit requirements without a hearing;
- 28           ▶ amends the date before which a health insurer shall submit a written report  
29 regarding coverage for opioids;
- 30           ▶ amends provisions regarding credit allowed a domestic ceding insurer against  
31 reserves for reinsurance, including:
- 32           • establishing eligibility for credit;
- 33           • requiring the insurance commissioner to create and publish a list of reciprocal  
34 jurisdictions;
- 35           • requiring the insurance commissioner to create and publish a list of qualified  
36 assuming insurers;
- 37           • requiring rulemaking;
- 38           • establishing conditions for suspension of an assuming insurer's eligibility; and  
39           • addressing the reduction or elimination of credit;
- 40           ▶ amends requirements for the loss and loss adjustment expense factors included in  
41 rates filed in relation to workers' compensation;
- 42           ▶ amends certain filing requirements to reflect current practice;
- 43           ▶ amends the forms that the insurance commissioner may prohibit;
- 44           ▶ amends limitations of actions for an accident and health insurance policy;
- 45           ▶ enacts provisions regarding the Restatement of the Law of Liability Insurance;
- 46           ▶ outlines requirements for a notice of assignment related to a debt;
- 47           ▶ amends requirements related to the shared common purposes of association groups;
- 48           ▶ amends provisions regarding dependent coverage for accident and health insurance;
- 49           ▶ enacts the Limited Long-Term Care Insurance Act, which:
- 50           • defines terms;
- 51           • establishes disclosure and performance standards for limited long-term care  
52 insurance;
- 53           • establishes parameters of a limited long-term care insurance policy offering a  
54 nonforfeiture benefit; and
- 55           • requires the insurance commissioner to make rules;
- 56           ▶ amends provisions regarding the licensing of administrators;

- 57           ▶ amends jurisdictional provisions under the Insurance Receivership Act; and
- 58           ▶ permits a captive insurance company to provide reinsurance by another insurer with
- 59 prior approval of the commissioner; and
- 60           ▶ makes technical and conforming changes.

61 **Money Appropriated in this Bill:**

62           None

63 **Other Special Clauses:**

64           None

65 **Utah Code Sections Affected:**

66 AMENDS:

67           **17B-2a-818.5**, as last amended by Laws of Utah 2018, Chapter 319

68           **19-1-206**, as last amended by Laws of Utah 2018, Chapter 319

69           **26-40-115**, as last amended by Laws of Utah 2019, Chapter 393

70           **31A-1-103**, as last amended by Laws of Utah 2017, Chapter 27

71           **31A-1-301**, as last amended by Laws of Utah 2019, Chapter 193

72           **31A-2-104**, as last amended by Laws of Utah 2014, Chapters 290 and 300

73           **31A-2-110**, as last amended by Laws of Utah 1986, Chapter 204

74           **31A-2-212**, as last amended by Laws of Utah 2016, Chapter 138

75           **31A-2-218**, as last amended by Laws of Utah 2015, Chapter 283

76           **31A-2-309**, as last amended by Laws of Utah 2016, Chapter 138

77           **31A-2-403**, as last amended by Laws of Utah 2019, Chapter 193

78           **31A-6a-101**, as last amended by Laws of Utah 2018, Chapter 319

79           **31A-6a-103**, as last amended by Laws of Utah 2015, Chapter 244

80           **31A-6a-104**, as last amended by Laws of Utah 2018, Chapter 319

81           **31A-8-211**, as last amended by Laws of Utah 2002, Chapter 308

82           **31A-17-404**, as last amended by Laws of Utah 2017, Chapter 168

83           **31A-17-404.3**, as last amended by Laws of Utah 2016, Chapter 138

84           **31A-17-601**, as last amended by Laws of Utah 2001, Chapter 116

85           **31A-19a-404**, as renumbered and amended by Laws of Utah 1999, Chapter 130

86           **31A-19a-405**, as renumbered and amended by Laws of Utah 1999, Chapter 130

87           **31A-19a-406**, as renumbered and amended by Laws of Utah 1999, Chapter 130

- 88            **31A-21-201**, as last amended by Laws of Utah 2019, Chapter 193
- 89            **31A-21-301**, as last amended by Laws of Utah 2010, Chapter 10
- 90            **31A-21-313**, as last amended by Laws of Utah 2015, Chapter 244
- 91            **31A-22-412**, as last amended by Laws of Utah 1986, Chapter 204
- 92            **31A-22-413**, as last amended by Laws of Utah 2013, Chapter 264
- 93            **31A-22-505**, as last amended by Laws of Utah 2017, Chapter 168
- 94            **31A-22-610.5**, as last amended by Laws of Utah 2018, Chapter 443
- 95            **31A-22-615.5**, as enacted by Laws of Utah 2017, Chapter 53
- 96            **31A-23a-111**, as last amended by Laws of Utah 2019, Chapter 193
- 97            **31A-23a-205**, as renumbered and amended by Laws of Utah 2003, Chapter 298
- 98            **31A-23a-415**, as last amended by Laws of Utah 2019, Chapter 193
- 99            **31A-23b-401**, as last amended by Laws of Utah 2019, Chapter 193
- 100           **31A-25-208**, as last amended by Laws of Utah 2019, Chapter 193
- 101           **31A-26-206**, as last amended by Laws of Utah 2014, Chapters 290 and 300
- 102           **31A-26-213**, as last amended by Laws of Utah 2019, Chapter 193
- 103           **31A-26-301.6**, as last amended by Laws of Utah 2009, Chapter 11
- 104           **31A-27a-105**, as enacted by Laws of Utah 2007, Chapter 309
- 105           **31A-27a-501**, as enacted by Laws of Utah 2007, Chapter 309
- 106           **31A-30-117**, as last amended by Laws of Utah 2015, Chapter 283
- 107           **31A-30-118**, as last amended by Laws of Utah 2019, Chapter 193
- 108           **31A-35-402**, as last amended by Laws of Utah 2016, Chapter 234
- 109           **31A-37-303**, as last amended by Laws of Utah 2017, Chapter 168
- 110           **31A-37-701**, as enacted by Laws of Utah 2019, Chapter 193
- 111           **34A-2-202**, as last amended by Laws of Utah 2009, Chapter 212
- 112           **63A-5-205.5**, as enacted by Laws of Utah 2018, Chapter 319
- 113           **63C-9-403**, as last amended by Laws of Utah 2018, Chapter 319
- 114           **72-6-107.5**, as last amended by Laws of Utah 2018, Chapter 319
- 115           **79-2-404**, as last amended by Laws of Utah 2018, Chapter 319

116 ENACTS:

- 117            **31A-22-205**, Utah Code Annotated 1953
- 118            **31A-22-2001**, Utah Code Annotated 1953

- 119 [31A-22-2002](#), Utah Code Annotated 1953
- 120 [31A-22-2003](#), Utah Code Annotated 1953
- 121 [31A-22-2004](#), Utah Code Annotated 1953
- 122 [31A-22-2005](#), Utah Code Annotated 1953
- 123 [31A-22-2006](#), Utah Code Annotated 1953

---

124

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

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

127 **17B-2a-818.5. Contracting powers of public transit districts -- Health insurance**  
128 **coverage.**

129 (1) As used in this section:

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

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

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

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

136 (ii) meets employer eligibility waiting requirements for health care insurance, which  
137 may not exceed the first day of the calendar month following 60 days after the day on which  
138 the individual is hired.

139 (d) "Health benefit plan" means:

140 (i) the same as that term is defined in Section [31A-1-301](#)[:]; or

141 (ii) an employee welfare benefit plan:

142 (A) established under the Employee Retirement Income Security Act of 1974, 29  
143 U.S.C. Sec. 1001 et seq.;

144 (B) for an employer with 100 or more employees; and

145 (C) in which the employer establishes a self-funded or partially self-funded group  
146 health plan to provide medical care for the employer's employees and dependents of the  
147 employees.

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

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

151 (g) "Third party administrator" or "administrator" means the same as that term is  
152 defined in Section [31A-1-301](#).

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

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

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

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

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

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

164 (c) the contract is an emergency procurement.

165 (4) A person that intentionally uses change orders, contract modifications, or multiple  
166 contracts to circumvent the requirements of this section is guilty of an infraction.

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

171 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with  
172 Section [26-40-115](#);

173 (ii) is from:

174 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

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

177 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
178 an actuary or underwriter selected by a third party administrator; and

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

180 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)

181 shall provide the actuary or underwriter selected by an administrator, as described in  
182 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
183 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the  
184 requirements of qualified health coverage.

185 (ii) A contractor may not make a change to the contractor's contribution to the health  
186 benefit plan, unless the contractor provides notice to:

187 (A) the actuary or underwriter selected by an administrator as described in Subsection  
188 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
189 Subsection (5)(a) in compliance with this section; and

190 (B) the public transit district.

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

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

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

198 (A) the subcontractor offers qualified health ~~[insurance]~~ coverage that complies with  
199 Section 26-40-115;

200 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, ~~[or]~~  
201 an underwriter who is responsible for developing the employer group's premium rates, or if the  
202 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or  
203 underwriter selected by an administrator; and

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

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

210 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
211 and maintain an offer of qualified health ~~[insurance]~~ coverage described in Subsection

212 (5)(~~(b)~~)(c)(i).

213 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
214 [~~insurance~~] coverage described in Subsection (5)(~~(b)~~)(c)(i) during the duration of the  
215 subcontract is subject to penalties in accordance with an ordinance adopted by the public transit  
216 district under Subsection (6).

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

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

220 (a) in coordination with:

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

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

223 (iii) the State Building Board in accordance with Section 63A-5-205.5;

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

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

226 (b) that establish:

227 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
228 demonstrate compliance with this section, including:

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

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

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

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

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

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

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



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

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

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

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

256 (A) the employer relied in good faith on a written statement described in Subsection  
257 (5)(a) or (5)(~~b~~)(c)(ii); or

258 (B) a department or division determines that compliance with this section is not  
259 required under the provisions of Subsection (3).

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

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

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

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

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

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

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

273 (10) An administrator, including an administrator's actuary or underwriter, who

274 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
275 coverage of a contractor or subcontractor who provides a health benefit plan described in  
276 Subsection (1)(d)(ii):

277 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
278 unless the administrator commits gross negligence in preparing the written statement;

279 (b) is not liable for any error in the written statement if the administrator relied in good  
280 faith on information from the contractor or subcontractor; and

281 (c) may require as a condition of providing the written statement that a contractor or  
282 subcontractor hold the administrator harmless for an action arising under this section.

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

284 **19-1-206. Contracting powers of department -- Health insurance coverage.**

285 (1) As used in this section:

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

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

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

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

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

295 (d) "Health benefit plan" means:

296 (i) the same as that term is defined in Section [31A-1-301](#)~~[-]~~; or

297 (ii) an employee welfare benefit plan:

298 (A) established under the Employee Retirement Income Security Act of 1974, 29  
299 U.S.C. Sec. 1001 et seq.;

300 (B) for an employer with 100 or more employees; and

301 (C) in which the employer establishes a self-funded or partially self-funded group  
302 health plan to provide medical care for the employer's employees and dependents of the  
303 employees.

304 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in

305 Section [26-40-115](#).

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

307 (g) "Third party administrator" or "administrator" means the same as that term is  
308 defined in Section [31A-1-301](#).

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

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

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

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

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

319 (b) the contract or agreement is between:

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

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

322 (B) the federal government;

323 (C) another state;

324 (D) an interstate agency;

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

326 (F) a political subdivision of another state;

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

330 (d) the contract is:

331 (i) a sole source contract; or

332 (ii) an emergency procurement.

333 (4) A person that intentionally uses change orders, contract modifications, or multiple  
334 contracts to circumvent the requirements of this section is guilty of an infraction.

335 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the

336 executive director that the contractor has and will maintain an offer of qualified health  
337 [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the  
338 duration of the contract by submitting to the executive director a written statement that:

339 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with  
340 Section 26-40-115;

341 (ii) is from:

342 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

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

345 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
346 an actuary or underwriter selected by a third party administrator; and

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

348 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)  
349 shall provide the actuary or underwriter selected by an administrator, as described in  
350 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
351 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the  
352 requirements of qualified health coverage.

353 (ii) A contractor may not make a change to the contractor's contribution to the health  
354 benefit plan, unless the contractor provides notice to:

355 (A) the actuary or underwriter selected by an administrator, as described in Subsection  
356 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
357 Subsection (5)(a) in compliance with this section; and

358 (B) the department.

359 [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:

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

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

366 (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with

367 Section [26-40-115](#);

368 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [or]  
369 an underwriter who is responsible for developing the employer group's premium rates, or if the  
370 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or  
371 underwriter selected by an administrator; and

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

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

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

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

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

387 (6) The department shall adopt administrative rules:

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

389 (b) in coordination with:

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

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

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

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

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

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

396 (c) that establish:

397 (i) the requirements and procedures a contractor and a subcontractor shall follow to

398 demonstrate compliance with this section, including:

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

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

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

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

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

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

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

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

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

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

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

426 (A) the employer relied in good faith on a written statement described in Subsection  
427 (5)(a) or (5)~~(b)~~(c)(ii); or

428 (B) the department determines that compliance with this section is not required under

429 the provisions of Subsection (3).

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

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

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

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

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

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

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

443 (10) An administrator, including an administrator's actuary or underwriter, who  
444 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
445 coverage of a contractor or subcontractor who provides a health benefit plan described in  
446 Subsection (1)(d)(ii):

447 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
448 unless the administrator commits gross negligence in preparing the written statement;

449 (b) is not liable for any error in the written statement if the administrator relied in good  
450 faith on information from the contractor or subcontractor; and

451 (c) may require as a condition of providing the written statement that a contractor or  
452 subcontractor hold the administrator harmless for an action arising under this section.

453 Section 3. Section 26-40-115 is amended to read:

454 **26-40-115. State contractor -- Employee and dependent health benefit plan**  
455 **coverage.**

456 (1) For purposes of Sections 17B-2a-818.5, 19-1-206, 63A-5-205.5, 63C-9-403,  
457 72-6-107.5, and 79-2-404, "qualified health [insurance] coverage" means, at the time the  
458 contract is entered into or renewed:

459 (a) a health benefit plan and employer contribution level with a combined actuarial

460 value at least actuarially equivalent to the combined actuarial value of:

461 (i) the benchmark plan determined by the program under Subsection

462 26-40-106(1)(a)[-]; and

463 (ii) a contribution level at which the employer pays at least 50% of the premium or

464 contribution amounts for the employee and the dependents of the employee who reside or work  
465 in the state; or

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

467 (i) has a deductible that is:

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

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

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

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

479 (2) The department shall:

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

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

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

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

487 Section 4. Section 31A-1-103 is amended to read:

488 **31A-1-103. Scope and applicability of title.**

489 (1) This title does not apply to:

490 (a) a retainer contract made by an attorney-at-law:



- 491 (i) with an individual client; and
- 492 (ii) under which fees are based on estimates of the nature and amount of services to be  
493 provided to the specific client;
- 494 (b) a contract similar to a contract described in Subsection (1)(a) made with a group of  
495 clients involved in the same or closely related legal matters;
- 496 (c) an arrangement for providing benefits that do not exceed a limited amount of  
497 consultations, advice on simple legal matters, either alone or in combination with referral  
498 services, or the promise of fee discounts for handling other legal matters;
- 499 (d) limited legal assistance on an informal basis involving neither an express  
500 contractual obligation nor reasonable expectations, in the context of an employment,  
501 membership, educational, or similar relationship;
- 502 (e) legal assistance by employee organizations to their members in matters relating to  
503 employment;
- 504 (f) death, accident, health, or disability benefits provided to a person by an organization  
505 or its affiliate if:
  - 506 (i) the organization is tax exempt under Section 501(c)(3) of the Internal Revenue  
507 Code and has had its principal place of business in Utah for at least five years;
  - 508 (ii) the person is not an employee of the organization; and
  - 509 (iii) (A) substantially all the person's time in the organization is spent providing  
510 voluntary services:
    - 511 (I) in furtherance of the organization's purposes;
    - 512 (II) for a designated period of time; and
    - 513 (III) for which no compensation, other than expenses, is paid; or
  - 514 (B) the time since the service under Subsection (1)(f)(iii)(A) was completed is no more  
515 than 18 months; or
  - 516 (g) a prepaid contract of limited duration that provides for scheduled maintenance only.
- 517 (2) (a) This title restricts otherwise legitimate business activity.
- 518 (b) What this title does not prohibit is permitted unless contrary to other provisions of  
519 Utah law.
- 520 (3) Except as otherwise expressly provided, this title does not apply to:
  - 521 (a) those activities of an insurer where state jurisdiction is preempted by Section 514 of

522 the federal Employee Retirement Income Security Act of 1974, as amended;

523 (b) ocean marine insurance;

524 (c) death, accident, health, or disability benefits provided by an organization if the  
525 organization:

526 (i) has as ~~its~~ the organization's principal purpose to achieve charitable, educational,  
527 social, or religious objectives rather than to provide death, accident, health, or disability  
528 benefits;

529 (ii) does not incur a legal obligation to pay a specified amount; and

530 (iii) does not create reasonable expectations of receiving a specified amount on the part  
531 of an insured person;

532 (d) other business specified in rules adopted by the commissioner on a finding that:

533 (i) the transaction of the business in this state does not require regulation for the  
534 protection of the interests of the residents of this state; or

535 (ii) it would be impracticable to require compliance with this title;

536 (e) except as provided in Subsection (4), a transaction independently procured through  
537 negotiations under Section [31A-15-104](#);

538 (f) self-insurance;

539 (g) reinsurance;

540 (h) subject to Subsection (5), employee and labor union group or blanket insurance  
541 covering risks in this state if:

542 (i) the policyholder exists primarily for purposes other than to procure insurance;

543 (ii) the policyholder:

544 (A) is not a resident of this state;

545 (B) is not a domestic corporation; or

546 (C) does not have ~~its~~ the policyholder's principal office in this state;

547 (iii) no more than 25% of the certificate holders or insureds are residents of this state;

548 (iv) on request of the commissioner, the insurer files with the department a copy of the  
549 policy and a copy of each form or certificate; and

550 (v) (A) the insurer agrees to pay premium taxes on the Utah portion of ~~its~~ the  
551 insurer's business, as if ~~it~~ the insurer were authorized to do business in this state; and

552 (B) the insurer provides the commissioner with the security the commissioner

553 considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of  
554 Admitted Insurers;

555 (i) to the extent provided in Subsection (6):

556 (i) a manufacturer's or seller's warranty; and

557 (ii) a manufacturer's or seller's service contract;

558 (j) except to the extent provided in Subsection (7), a public agency insurance mutual;

559 or

560 (k) except as provided in Chapter 6b, Guaranteed Asset Protection Waiver Act, a

561 guaranteed asset protection waiver.

562 (4) A transaction described in Subsection (3)(e) is subject to taxation under Section

563 [31A-3-301](#).

564 (5) (a) After a hearing, the commissioner may order an insurer of certain group or

565 blanket contracts to transfer the Utah portion of the business otherwise exempted under

566 Subsection (3)(h) to an authorized insurer if the contracts have been written by an unauthorized

567 insurer.

568 (b) If the commissioner finds that the conditions required for the exemption of a group

569 or blanket insurer are not satisfied or that adequate protection to residents of this state is not

570 provided, the commissioner may require:

571 (i) the insurer to be authorized to do business in this state; or

572 (ii) that any of the insurer's transactions be subject to this title.

573 (c) Subsection (3)(h) does not apply to blanket accident and health insurance.

574 (6) (a) As used in Subsection (3)(i) and this Subsection (6):

575 (i) "manufacturer's or seller's service contract" means a service contract:

576 (A) made available by:

577 (I) a manufacturer of a product;

578 (II) a seller of a product; or

579 (III) an affiliate of a manufacturer or seller of a product;

580 (B) made available:

581 (I) on one or more specific products; or

582 (II) on products that are components of a system; and

583 (C) under which the person described in Subsection (6)(a)(i)(A) is liable for services to

584 be provided under the service contract including, if the manufacturer's or seller's service  
585 contract designates, providing parts and labor;

586 (ii) "manufacturer's or seller's warranty" means the guaranty of:  
587 (A) (I) the manufacturer of a product;  
588 (II) a seller of a product; or  
589 (III) an affiliate of a manufacturer or seller of a product;  
590 (B) (I) on one or more specific products; or  
591 (II) on products that are components of a system; and  
592 (C) under which the person described in Subsection (6)(a)(ii)(A) is liable for services  
593 to be provided under the warranty, including, if the manufacturer's or seller's warranty  
594 designates, providing parts and labor; and

595 (iii) "service contract" means the same as that term is defined in Section [31A-6a-101](#).  
596 (b) A manufacturer's or seller's warranty may be designated as:  
597 (i) a warranty;  
598 (ii) a guaranty; or  
599 (iii) a term similar to a term described in Subsection (6)(b)(i) or (ii).  
600 (c) This title does not apply to:  
601 (i) a manufacturer's or seller's warranty;  
602 (ii) a manufacturer's or seller's service contract paid for with consideration that is in  
603 addition to the consideration paid for the product itself; and  
604 (iii) a service contract that is not a manufacturer's or seller's warranty or manufacturer's  
605 or seller's service contract if:  
606 (A) the service contract is paid for with consideration that is in addition to the  
607 consideration paid for the product itself;  
608 (B) the service contract is for the repair or maintenance of goods;  
609 (C) the ~~[cost]~~ purchase price of the product is ~~[equal to an amount determined in~~  
610 ~~accordance with Subsection (6)(c); and]~~ \$3,700 or less;  
611 (D) the product is not a motor vehicle~~[-];~~ and  
612 (E) the product is not the subject of a home warranty service contract.  
613 (d) This title does not apply to a manufacturer's or seller's warranty or service contract  
614 paid for with consideration that is in addition to the consideration paid for the product itself

615 regardless of whether the manufacturer's or seller's warranty or service contract is sold:

616 (i) at the time of the purchase of the product; or

617 (ii) at a time other than the time of the purchase of the product.

618 ~~[(e) (i) For fiscal year 2001-02, the amount described in Subsection (6)(c)(iii)(C) shall~~  
619 ~~be equal to \$3,700 or less.]~~

620 ~~[(ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually~~  
621 ~~determine whether the amount described in Subsection (6)(c)(iii)(C) should be adjusted in~~  
622 ~~accordance with changes in the Consumer Price Index published by the United States Bureau~~  
623 ~~of Labor Statistics selected by the commissioner by rule, between:]~~

624 ~~[(A) the Consumer Price Index for the February immediately preceding the adjustment;~~  
625 ~~and]~~

626 ~~[(B) the Consumer Price Index for February 2001.]~~

627 ~~[(iii) If under Subsection (6)(c)(ii) the commissioner determines that an adjustment~~  
628 ~~should be made, the commissioner shall make the adjustment by rule.]~~

629 (7) (a) For purposes of this Subsection (7), "public agency insurance mutual" means an  
630 entity formed by two or more political subdivisions or public agencies of the state:

631 (i) under Title 11, Chapter 13, Interlocal Cooperation Act; and

632 (ii) for the purpose of providing for the political subdivisions or public agencies:

633 (A) subject to Subsection (7)(b), insurance coverage; or

634 (B) risk management.

635 (b) Notwithstanding Subsection (7)(a)(ii)(A), a public agency insurance mutual may  
636 not provide health insurance unless the public agency insurance mutual provides the health  
637 insurance using:

638 (i) a third party administrator licensed under Chapter 25, Third Party Administrators;

639 (ii) an admitted insurer; or

640 (iii) a program authorized by Title 49, Chapter 20, Public Employees' Benefit and  
641 Insurance Program Act.

642 (c) Except for this Subsection (7), a public agency insurance mutual is exempt from  
643 this title.

644 (d) A public agency insurance mutual is considered to be a governmental entity and  
645 political subdivision of the state with all of the rights, privileges, and immunities of a

646 governmental entity or political subdivision of the state including all the rights and benefits of  
647 Title 63G, Chapter 7, Governmental Immunity Act of Utah.

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

649 **31A-1-301. Definitions.**

650 As used in this title, unless otherwise specified:

651 (1) (a) "Accident and health insurance" means insurance to provide protection against  
652 economic losses resulting from:

653 (i) a medical condition including:

654 (A) a medical care expense; or

655 (B) the risk of disability;

656 (ii) accident; or

657 (iii) sickness.

658 (b) "Accident and health insurance":

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

660 (A) an income replacement contract;

661 (B) a health care contract;

662 (C) an expense reimbursement contract;

663 (D) a credit accident and health contract;

664 (E) a continuing care contract; and

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

666 (ii) may provide:

667 (A) hospital coverage;

668 (B) surgical coverage;

669 (C) medical coverage;

670 (D) loss of income coverage;

671 (E) prescription drug coverage;

672 (F) dental coverage; or

673 (G) vision coverage.

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

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

677 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title  
678 63G, Chapter 3, Utah Administrative Rulemaking Act.

679 (3) "Administrator" means the same as that term is defined in Subsection [~~(178)~~] (179).

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

681 (5) "Affiliate" means a person who controls, is controlled by, or is under common  
682 control with, another person. A corporation is an affiliate of another corporation, regardless of  
683 ownership, if substantially the same group of individuals manage the corporations.

684 (6) "Agency" means:

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

687 (b) an insurance organization licensed or required to be licensed under Section  
688 [31A-23a-301](#), [31A-25-207](#), or [31A-26-209](#).

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

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

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

695 (10) "Application" means a document:

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

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

700 (A) insure the risk under:

701 (I) the coverage as originally offered; or

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

703 (B) decline to insure the risk; or

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

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

707 (a) the original articles;

- 708 (b) a special law;
- 709 (c) a charter;
- 710 (d) an amendment;
- 711 (e) restated articles;
- 712 (f) articles of merger or consolidation;
- 713 (g) a trust instrument;
- 714 (h) another constitutive document for a trust or other entity that is not a corporation;

715 and

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

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

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

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

- 723 (a) without individual underwriting or application; and

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

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

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

- 728 (a) that is open to the public;

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

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

731 (17) "Business entity" means:

- 732 (a) a corporation;

733 (b) an association;

734 (c) a partnership;

735 (d) a limited liability company;

736 (e) a limited liability partnership; or

737 (f) another legal entity.

738 (18) "Business of insurance" means the same as that term is defined in Subsection (94).



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

- 742 (a) Section 31A-8-205; or
- 743 (b) Subsection 31A-9-205(2).

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

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

748 (21) "Captive insurance company" means:

- 749 (a) an insurer:
  - 750 (i) owned by another organization; and
  - 751 (ii) whose exclusive purpose is to insure risks of the parent organization and an  
752 affiliated company; or

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

- 754 (i) owned by the insureds; and
- 755 (ii) whose exclusive purpose is to insure risks of:
  - 756 (A) a member organization;
  - 757 (B) a group member; or
  - 758 (C) an affiliate of:
    - 759 (I) a member organization; or
    - 760 (II) a group member.

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

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

- 763 (a) an insured under a group insurance policy; or
- 764 (b) a third party.

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

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

768 (26) "Claims-made coverage" means an insurance contract or provision limiting  
769 coverage under a policy insuring against legal liability to claims that are first made against the

770 insured while the policy is in force.

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

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

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

776 (i) provides board and lodging;

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

778 (A) a personal service;

779 (B) a nursing service;

780 (C) a medical service; or

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

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

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

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

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

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

791 (i) by contract;

792 (ii) by common management;

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

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

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

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

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

801 voting securities of another person.

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

804 (31) "Controlling person" means a person that directly or indirectly has the power to  
805 direct or cause to be directed, the management, control, or activities of a reinsurance  
806 intermediary.

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

809 (33) "Corporate governance annual disclosure" means a report an insurer or insurance  
810 group files in accordance with the requirements of Chapter 16b, Corporate Governance Annual  
811 Disclosure Act.

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

813 (i) a corporation doing business:

814 (A) as:

815 (I) an insurance producer;

816 (II) a surplus lines producer;

817 (III) a limited line producer;

818 (IV) a consultant;

819 (V) a managing general agent;

820 (VI) a reinsurance intermediary;

821 (VII) a third party administrator; or

822 (VIII) an adjuster; and

823 (B) under:

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

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

827 (III) Chapter 26, Insurance Adjusters; or

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

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

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

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

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

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

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

839 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.  
840 No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No.  
841 109-415.

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

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

847 (b) "Credit insurance" includes:

848 (i) credit accident and health insurance;

849 (ii) credit life insurance;

850 (iii) credit property insurance;

851 (iv) credit unemployment insurance;

852 (v) guaranteed automobile protection insurance;

853 (vi) involuntary unemployment insurance;

854 (vii) mortgage accident and health insurance;

855 (viii) mortgage guaranty insurance; and

856 (ix) mortgage life insurance.

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

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

860 (a) matured;

861 (b) unmatured;

862 (c) liquidated;

- 863 (d) unliquidated;
- 864 (e) secured;
- 865 (f) unsecured;
- 866 (g) absolute;
- 867 (h) fixed; or
- 868 (i) contingent.
- 869 (40) "Credit property insurance" means insurance:
- 870 (a) offered in connection with an extension of credit; and
- 871 (b) that protects the property until the debt is paid.
- 872 (41) "Credit unemployment insurance" means insurance:
- 873 (a) offered in connection with an extension of credit; and
- 874 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
- 875 (i) specific loan; or
- 876 (ii) credit transaction.
- 877 (42) (a) "Crop insurance" means insurance providing protection against damage to
- 878 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,
- 879 disease, or other yield-reducing conditions or perils that is:
- 880 (i) provided by the private insurance market; or
- 881 (ii) subsidized by the Federal Crop Insurance Corporation.
- 882 (b) "Crop insurance" includes multiperil crop insurance.
- 883 (43) (a) "Customer service representative" means a person that provides an insurance
- 884 service and insurance product information:
- 885 (i) for the customer service representative's:
- 886 (A) producer;
- 887 (B) surplus lines producer; or
- 888 (C) consultant employer; and
- 889 (ii) to the customer service representative's employer's:
- 890 (A) customer;
- 891 (B) client; or
- 892 (C) organization.
- 893 (b) A customer service representative may only operate within the scope of authority of

894 the customer service representative's producer, surplus lines producer, or consultant employer.

895 (44) "Deadline" means a final date or time:

896 (a) imposed by:

897 (i) statute;

898 (ii) rule; or

899 (iii) order; and

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

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

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

908 (47) "Department" means the Insurance Department.

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

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

912 (a) perform the duties of:

913 (i) that individual's occupation; or

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

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

917 (i) eating;

918 (ii) toileting;

919 (iii) transferring;

920 (iv) bathing; or

921 (v) dressing.

922 (50) "Disability income insurance" means the same as that term is defined in  
923 Subsection (85).

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

- 925 (52) "Domiciliary state" means the state in which an insurer:  
926 (a) is incorporated;  
927 (b) is organized; or  
928 (c) in the case of an alien insurer, enters into the United States.
- 929 (53) (a) "Eligible employee" means:  
930 (i) an employee who:  
931 (A) works on a full-time basis; and  
932 (B) has a normal work week of 30 or more hours; or  
933 (ii) a person described in Subsection (53)(b).
- 934 (b) "Eligible employee" includes:  
935 (i) an owner who:  
936 (A) works on a full-time basis; [~~and~~]  
937 (B) has a normal work week of 30 or more hours; and  
938 (C) employs at least one common employee; and  
939 (ii) if the individual is included under a health benefit plan of a small employer:  
940 (A) a sole proprietor;  
941 (B) a partner in a partnership; or  
942 (C) an independent contractor.
- 943 (c) "Eligible employee" does not include, unless eligible under Subsection (53)(b):  
944 (i) an individual who works on a temporary or substitute basis for a small employer;  
945 (ii) an employer's spouse who does not meet the requirements of Subsection (53)(a)(i);  
946 or  
947 (iii) a dependent of an employer who does not meet the requirements of Subsection  
948 (53)(a)(i).
- 949 (54) "Employee" means:  
950 (a) an individual employed by an employer; and  
951 (b) an owner who meets the requirements of Subsection (53)(b)(i).
- 952 (55) "Employee benefits" means one or more benefits or services provided to:  
953 (a) an employee; or  
954 (b) a dependent of an employee.
- 955 (56) (a) "Employee welfare fund" means a fund:

- 956 (i) established or maintained, whether directly or through a trustee, by:
- 957 (A) one or more employers;
- 958 (B) one or more labor organizations; or
- 959 (C) a combination of employers and labor organizations; and
- 960 (ii) that provides employee benefits paid or contracted to be paid, other than income
- 961 from investments of the fund:
- 962 (A) by or on behalf of an employer doing business in this state; or
- 963 (B) for the benefit of a person employed in this state.
- 964 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax
- 965 revenues.
- 966 (57) "Endorsement" means a written agreement attached to a policy or certificate to
- 967 modify the policy or certificate coverage.
- 968 (58) (a) "Enrollee" means:
- 969 (i) a policyholder;
- 970 (ii) a certificate holder;
- 971 (iii) a subscriber; or
- 972 (iv) a covered individual:
- 973 (A) who has entered into a contract with an organization for health care; or
- 974 (B) on whose behalf an arrangement for health care has been made.
- 975 (b) "Enrollee" includes an insured.
- 976 (59) "Enrollment date," with respect to a health benefit plan, means:
- 977 (a) the first day of coverage; or
- 978 (b) if there is a waiting period, the first day of the waiting period.
- 979 (60) "Enterprise risk" means an activity, circumstance, event, or series of events
- 980 involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a
- 981 material adverse effect upon the financial condition or liquidity of the insurer or its insurance
- 982 holding company system as a whole, including anything that would cause:
- 983 (a) the insurer's risk-based capital to fall into an action or control level as set forth in
- 984 Sections [31A-17-601](#) through [31A-17-613](#); or
- 985 (b) the insurer to be in hazardous financial condition set forth in Section [31A-27a-101](#).
- 986 (61) (a) "Escrow" means:



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

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

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

993 (ii) a settlement or closing involving:

994 (A) a mobile home;

995 (B) a grazing right;

996 (C) a water right; or

997 (D) other personal property authorized by the commissioner.

998 (b) "Escrow" does not include:

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

1000 (A) an acknowledgment;

1001 (B) a copy certification;

1002 (C) jurat; and

1003 (D) an oath or affirmation;

1004 (ii) the receipt or delivery of a document; or

1005 (iii) the receipt of money for delivery to the escrow agent.

1006 (62) "Escrow agent" means an agency title insurance producer meeting the

1007 requirements of Sections [31A-4-107](#), [31A-14-211](#), and [31A-23a-204](#), who is acting through an  
1008 individual title insurance producer licensed with an escrow subline of authority.

1009 (63) (a) "Excludes" is not exhaustive and does not mean that another thing is not also  
1010 excluded.

1011 (b) The items listed in a list using the term "excludes" are representative examples for  
1012 use in interpretation of this title.

1013 (64) "Exclusion" means for the purposes of accident and health insurance that an  
1014 insurer does not provide insurance coverage, for whatever reason, for one of the following:

1015 (a) a specific physical condition;

1016 (b) a specific medical procedure;

1017 (c) a specific disease or disorder; or

- 1018 (d) a specific prescription drug or class of prescription drugs.
- 1019 (65) "Expense reimbursement insurance" means insurance:
- 1020 (a) written to provide a payment for an expense relating to hospital confinement
- 1021 resulting from illness or injury; and
- 1022 (b) written:
- 1023 (i) as a daily limit for a specific number of days in a hospital; and
- 1024 (ii) to have a one or two day waiting period following a hospitalization.
- 1025 (66) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding
- 1026 a position of public or private trust.
- 1027 (67) (a) "Filed" means that a filing is:
- 1028 (i) submitted to the department as required by and in accordance with applicable
- 1029 statute, rule, or filing order;
- 1030 (ii) received by the department within the time period provided in applicable statute,
- 1031 rule, or filing order; and
- 1032 (iii) accompanied by the appropriate fee in accordance with:
- 1033 (A) Section [31A-3-103](#); or
- 1034 (B) rule.
- 1035 (b) "Filed" does not include a filing that is rejected by the department because it is not
- 1036 submitted in accordance with Subsection (67)(a).
- 1037 (68) "Filing," when used as a noun, means an item required to be filed with the
- 1038 department including:
- 1039 (a) a policy;
- 1040 (b) a rate;
- 1041 (c) a form;
- 1042 (d) a document;
- 1043 (e) a plan;
- 1044 (f) a manual;
- 1045 (g) an application;
- 1046 (h) a report;
- 1047 (i) a certificate;
- 1048 (j) an endorsement;

- 1049 (k) an actuarial certification;
- 1050 (l) a licensee annual statement;
- 1051 (m) a licensee renewal application;
- 1052 (n) an advertisement;
- 1053 (o) a binder; or
- 1054 (p) an outline of coverage.
- 1055 (69) "First party insurance" means an insurance policy or contract in which the insurer
- 1056 agrees to pay a claim submitted to it by the insured for the insured's losses.
- 1057 (70) "Foreign insurer" means an insurer domiciled outside of this state, including an
- 1058 alien insurer.
- 1059 (71) (a) "Form" means one of the following prepared for general use:
- 1060 (i) a policy;
- 1061 (ii) a certificate;
- 1062 (iii) an application;
- 1063 (iv) an outline of coverage; or
- 1064 (v) an endorsement.
- 1065 (b) "Form" does not include a document specially prepared for use in an individual
- 1066 case.
- 1067 (72) "Franchise insurance" means an individual insurance policy provided through a
- 1068 mass marketing arrangement involving a defined class of persons related in some way other
- 1069 than through the purchase of insurance.
- 1070 (73) "General lines of authority" include:
- 1071 (a) the general lines of insurance in Subsection (74);
- 1072 (b) title insurance under one of the following sublines of authority:
- 1073 (i) title examination, including authority to act as a title marketing representative;
- 1074 (ii) escrow, including authority to act as a title marketing representative; and
- 1075 (iii) title marketing representative only;
- 1076 (c) surplus lines;
- 1077 (d) workers' compensation; and
- 1078 (e) another line of insurance that the commissioner considers necessary to recognize in
- 1079 the public interest.

- 1080 (74) "General lines of insurance" include:
- 1081 (a) accident and health;
- 1082 (b) casualty;
- 1083 (c) life;
- 1084 (d) personal lines;
- 1085 (e) property; and
- 1086 (f) variable contracts, including variable life and annuity.
- 1087 (75) "Group health plan" means an employee welfare benefit plan to the extent that the
- 1088 plan provides medical care:
- 1089 (a) (i) to an employee; or
- 1090 (ii) to a dependent of an employee; and
- 1091 (b) (i) directly;
- 1092 (ii) through insurance reimbursement; or
- 1093 (iii) through another method.
- 1094 (76) (a) "Group insurance policy" means a policy covering a group of persons that is
- 1095 issued:
- 1096 (i) to a policyholder on behalf of the group; and
- 1097 (ii) for the benefit of a member of the group who is selected under a procedure defined
- 1098 in:
- 1099 (A) the policy; or
- 1100 (B) an agreement that is collateral to the policy.
- 1101 (b) A group insurance policy may include a member of the policyholder's family or a
- 1102 dependent.
- 1103 (77) "Group-wide supervisor" means the commissioner or other regulatory official
- 1104 designated as the group-wide supervisor for an internationally active insurance group under
- 1105 Section [31A-16-108.6](#).
- 1106 (78) "Guaranteed automobile protection insurance" means insurance offered in
- 1107 connection with an extension of credit that pays the difference in amount between the
- 1108 insurance settlement and the balance of the loan if the insured automobile is a total loss.
- 1109 (79) (a) "Health benefit plan" means, except as provided in Subsection (79)(b), a
- 1110 policy, contract, certificate, or agreement offered or issued by a health carrier to provide,

1111 deliver, arrange for, pay for, or reimburse any of the costs of health care.

1112 (b) "Health benefit plan" does not include:

1113 (i) coverage only for accident or disability income insurance, or any combination

1114 thereof;

1115 (ii) coverage issued as a supplement to liability insurance;

1116 (iii) liability insurance, including general liability insurance and automobile liability

1117 insurance;

1118 (iv) workers' compensation or similar insurance;

1119 (v) automobile medical payment insurance;

1120 (vi) credit-only insurance;

1121 (vii) coverage for on-site medical clinics;

1122 (viii) other similar insurance coverage, specified in federal regulations issued pursuant

1123 to Pub. L. No. 104-191, under which benefits for health care services are secondary or

1124 incidental to other insurance benefits;

1125 (ix) the following benefits if they are provided under a separate policy, certificate, or

1126 contract of insurance or are otherwise not an integral part of the plan:

1127 (A) limited scope dental or vision benefits;

1128 (B) benefits for long-term care, nursing home care, home health care,

1129 community-based care, or any combination thereof; or

1130 (C) other similar limited benefits, specified in federal regulations issued pursuant to

1131 Pub. L. No. 104-191;

1132 (x) the following benefits if the benefits are provided under a separate policy,

1133 certificate, or contract of insurance, there is no coordination between the provision of benefits

1134 and any exclusion of benefits under any health plan, and the benefits are paid with respect to an

1135 event without regard to whether benefits are provided under any health plan:

1136 (A) coverage only for specified disease or illness; or

1137 (B) hospital indemnity or other fixed indemnity insurance; [~~and~~]

1138 (xi) the following if offered as a separate policy, certificate, or contract of insurance:

1139 (A) Medicare supplemental health insurance as defined under the Social Security Act,

1140 42 U.S.C. Sec. 1395ss(g)(1);

1141 (B) coverage supplemental to the coverage provided under United States Code, Title

1142 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services  
1143 (CHAMPUS); or  
1144 (C) similar supplemental coverage provided to coverage under a group health insurance  
1145 plan[-];  
1146 (xii) short-term, limited-duration insurance; and  
1147 (xiii) student health insurance, except as required under 45 C.F.R. Sec. 147.145.  
1148 (80) "Health care" means any of the following intended for use in the diagnosis,  
1149 treatment, mitigation, or prevention of a human ailment or impairment:  
1150 (a) a professional service;  
1151 (b) a personal service;  
1152 (c) a facility;  
1153 (d) equipment;  
1154 (e) a device;  
1155 (f) supplies; or  
1156 (g) medicine.  
1157 (81) (a) "Health care insurance" or "health insurance" means insurance providing:  
1158 (i) a health care benefit; or  
1159 (ii) payment of an incurred health care expense.  
1160 (b) "Health care insurance" or "health insurance" does not include accident and health  
1161 insurance providing a benefit for:  
1162 (i) replacement of income;  
1163 (ii) short-term accident;  
1164 (iii) fixed indemnity;  
1165 (iv) credit accident and health;  
1166 (v) supplements to liability;  
1167 (vi) workers' compensation;  
1168 (vii) automobile medical payment;  
1169 (viii) no-fault automobile;  
1170 (ix) equivalent self-insurance; or  
1171 (x) a type of accident and health insurance coverage that is a part of or attached to  
1172 another type of policy.

- 1173 (82) "Health care provider" means the same as that term is defined in Section  
1174 [78B-3-403](#).
- 1175 (83) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec.  
1176 155.20.
- 1177 (84) "Health Insurance Portability and Accountability Act" means the Health Insurance  
1178 Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.
- 1179 (85) "Income replacement insurance" or "disability income insurance" means insurance  
1180 written to provide payments to replace income lost from accident or sickness.
- 1181 (86) "Indemnity" means the payment of an amount to offset all or part of an insured  
1182 loss.
- 1183 (87) "Independent adjuster" means an insurance adjuster required to be licensed under  
1184 Section [31A-26-201](#) who engages in insurance adjusting as a representative of an insurer.
- 1185 (88) "Independently procured insurance" means insurance procured under Section  
1186 [31A-15-104](#).
- 1187 (89) "Individual" means a natural person.
- 1188 (90) "Inland marine insurance" includes insurance covering:
- 1189 (a) property in transit on or over land;
- 1190 (b) property in transit over water by means other than boat or ship;
- 1191 (c) bailee liability;
- 1192 (d) fixed transportation property such as bridges, electric transmission systems, radio  
1193 and television transmission towers and tunnels; and
- 1194 (e) personal and commercial property floaters.
- 1195 (91) "Insolvency" or "insolvent" means that:
- 1196 (a) an insurer is unable to pay the insurer's obligations as the obligations are due;
- 1197 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level  
1198 RBC under Subsection [31A-17-601](#)(8)(c); or
- 1199 (c) an insurer's admitted assets are less than the insurer's liabilities.
- 1200 (92) (a) "Insurance" means:
- 1201 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more  
1202 persons to one or more other persons; or
- 1203 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a

1204 group of persons that includes the person seeking to distribute that person's risk.

1205 (b) "Insurance" includes:

1206 (i) a risk distributing arrangement providing for compensation or replacement for  
1207 damages or loss through the provision of a service or a benefit in kind;

1208 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a  
1209 business and not as merely incidental to a business transaction; and

1210 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,  
1211 but with a class of persons who have agreed to share the risk.

1212 (93) "Insurance adjuster" means a person who directs or conducts the investigation,  
1213 negotiation, or settlement of a claim under an insurance policy other than life insurance or an  
1214 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

1215 (94) "Insurance business" or "business of insurance" includes:

1216 (a) providing health care insurance by an organization that is or is required to be  
1217 licensed under this title;

1218 (b) providing a benefit to an employee in the event of a contingency not within the  
1219 control of the employee, in which the employee is entitled to the benefit as a right, which  
1220 benefit may be provided either:

1221 (i) by a single employer or by multiple employer groups; or

1222 (ii) through one or more trusts, associations, or other entities;

1223 (c) providing an annuity:

1224 (i) including an annuity issued in return for a gift; and

1225 (ii) except an annuity provided by a person specified in Subsections [31A-22-1305\(2\)](#)

1226 and (3);

1227 (d) providing the characteristic services of a motor club as outlined in Subsection  
1228 (125);

1229 (e) providing another person with insurance;

1230 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,  
1231 or surety, a contract or policy of title insurance;

1232 (g) transacting or proposing to transact any phase of title insurance, including:

1233 (i) solicitation;

1234 (ii) negotiation preliminary to execution;



- 1235 (iii) execution of a contract of title insurance;
- 1236 (iv) insuring; and
- 1237 (v) transacting matters subsequent to the execution of the contract and arising out of
- 1238 the contract, including reinsurance;
- 1239 (h) transacting or proposing a life settlement; and
- 1240 (i) doing, or proposing to do, any business in substance equivalent to Subsections
- 1241 (94)(a) through (h) in a manner designed to evade this title.
- 1242 (95) "Insurance consultant" or "consultant" means a person who:
- 1243 (a) advises another person about insurance needs and coverages;
- 1244 (b) is compensated by the person advised on a basis not directly related to the insurance
- 1245 placed; and
- 1246 (c) except as provided in Section [31A-23a-501](#), is not compensated directly or
- 1247 indirectly by an insurer or producer for advice given.
- 1248 (96) "Insurance group" means the persons that comprise an insurance holding company
- 1249 system.
- 1250 (97) "Insurance holding company system" means a group of two or more affiliated
- 1251 persons, at least one of whom is an insurer.
- 1252 (98) (a) "Insurance producer" or "producer" means a person licensed or required to be
- 1253 licensed under the laws of this state to sell, solicit, or negotiate insurance.
- 1254 (b) (i) "Producer for the insurer" means a producer who is compensated directly or
- 1255 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that
- 1256 insurer.
- 1257 (ii) "Producer for the insurer" may be referred to as an "agent."
- 1258 (c) (i) "Producer for the insured" means a producer who:
- 1259 (A) is compensated directly and only by an insurance customer or an insured; and
- 1260 (B) receives no compensation directly or indirectly from an insurer for selling,
- 1261 soliciting, or negotiating an insurance product of that insurer to an insurance customer or
- 1262 insured.
- 1263 (ii) "Producer for the insured" may be referred to as a "broker."
- 1264 (99) (a) "Insured" means a person to whom or for whose benefit an insurer makes a
- 1265 promise in an insurance policy and includes:

- 1266 (i) a policyholder;
- 1267 (ii) a subscriber;
- 1268 (iii) a member; and
- 1269 (iv) a beneficiary.
- 1270 (b) The definition in Subsection (99)(a):
- 1271 (i) applies only to this title;
- 1272 (ii) does not define the meaning of "insured" as used in an insurance policy or
- 1273 certificate; and
- 1274 (iii) includes an enrollee.
- 1275 (100) (a) "Insurer" means a person doing an insurance business as a principal
- 1276 including:
- 1277 (i) a fraternal benefit society;
- 1278 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
- 1279 [31A-22-1305](#)(2) and (3);
- 1280 (iii) a motor club;
- 1281 (iv) an employee welfare plan;
- 1282 (v) a person purporting or intending to do an insurance business as a principal on that
- 1283 person's own account; and
- 1284 (vi) a health maintenance organization.
- 1285 (b) "Insurer" does not include a governmental entity.
- 1286 (101) "Interinsurance exchange" means the same as that term is defined in Subsection
- 1287 (160).
- 1288 (102) "Internationally active insurance group" means an insurance holding company
- 1289 system:
- 1290 (a) that includes an insurer registered under Section [31A-16-105](#);
- 1291 (b) that has premiums written in at least three countries;
- 1292 (c) whose percentage of gross premiums written outside the United States is at least
- 1293 10% of its total gross written premiums; and
- 1294 (d) that, based on a three-year rolling average, has:
- 1295 (i) total assets of at least \$50,000,000,000; or
- 1296 (ii) total gross written premiums of at least \$10,000,000,000.

- 1297 (103) "Involuntary unemployment insurance" means insurance:  
1298 (a) offered in connection with an extension of credit; and  
1299 (b) that provides indemnity if the debtor is involuntarily unemployed for payments  
1300 coming due on a:  
1301 (i) specific loan; or  
1302 (ii) credit transaction.
- 1303 (104) ~~[(a)]~~ "Large employer," in connection with a health benefit plan, means an  
1304 employer who, with respect to a calendar year and to a plan year:  
1305 ~~[(i)]~~ (a) employed an average of at least 51 employees on business days during the  
1306 preceding calendar year; and  
1307 ~~[(ii)]~~ (b) employs at least one employee on the first day of the plan year.  
1308 ~~[(b) The number of employees shall be determined using the method set forth in 26~~  
1309 ~~U.S.C. Sec. 4980H(c)(2).]~~
- 1310 (105) "Late enrollee," with respect to an employer health benefit plan, means an  
1311 individual whose enrollment is a late enrollment.
- 1312 (106) "Late enrollment," with respect to an employer health benefit plan, means  
1313 enrollment of an individual other than:  
1314 (a) on the earliest date on which coverage can become effective for the individual  
1315 under the terms of the plan; or  
1316 (b) through special enrollment.
- 1317 (107) (a) Except for a retainer contract or legal assistance described in Section  
1318 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a  
1319 specified legal expense.  
1320 (b) "Legal expense insurance" includes an arrangement that creates a reasonable  
1321 expectation of an enforceable right.  
1322 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,  
1323 legal services incidental to other insurance coverage.
- 1324 (108) (a) "Liability insurance" means insurance against liability:  
1325 (i) for death, injury, or disability of a human being, or for damage to property,  
1326 exclusive of the coverages under:  
1327 (A) medical malpractice insurance;

- 1328 (B) professional liability insurance; and  
1329 (C) workers' compensation insurance;  
1330 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the  
1331 insured who is injured, irrespective of legal liability of the insured, when issued with or  
1332 supplemental to insurance against legal liability for the death, injury, or disability of a human  
1333 being, exclusive of the coverages under:  
1334 (A) medical malpractice insurance;  
1335 (B) professional liability insurance; and  
1336 (C) workers' compensation insurance;  
1337 (iii) for loss or damage to property resulting from an accident to or explosion of a  
1338 boiler, pipe, pressure container, machinery, or apparatus;  
1339 (iv) for loss or damage to property caused by:  
1340 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or  
1341 (B) water entering through a leak or opening in a building; or  
1342 (v) for other loss or damage properly the subject of insurance not within another kind  
1343 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.  
1344 (b) "Liability insurance" includes:  
1345 (i) vehicle liability insurance;  
1346 (ii) residential dwelling liability insurance; and  
1347 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,  
1348 boiler, machinery, or apparatus of any kind when done in connection with insurance on the  
1349 elevator, boiler, machinery, or apparatus.  
1350 (109) (a) "License" means authorization issued by the commissioner to engage in an  
1351 activity that is part of or related to the insurance business.  
1352 (b) "License" includes a certificate of authority issued to an insurer.  
1353 (110) (a) "Life insurance" means:  
1354 (i) insurance on a human life; and  
1355 (ii) insurance pertaining to or connected with human life.  
1356 (b) The business of life insurance includes:  
1357 (i) granting a death benefit;  
1358 (ii) granting an annuity benefit;

- 1359 (iii) granting an endowment benefit;
- 1360 (iv) granting an additional benefit in the event of death by accident;
- 1361 (v) granting an additional benefit to safeguard the policy against lapse; and
- 1362 (vi) providing an optional method of settlement of proceeds.
- 1363 (111) "Limited license" means a license that:
- 1364 (a) is issued for a specific product of insurance; and
- 1365 (b) limits an individual or agency to transact only for that product or insurance.
- 1366 (112) "Limited line credit insurance" includes the following forms of insurance:
- 1367 (a) credit life;
- 1368 (b) credit accident and health;
- 1369 (c) credit property;
- 1370 (d) credit unemployment;
- 1371 (e) involuntary unemployment;
- 1372 (f) mortgage life;
- 1373 (g) mortgage guaranty;
- 1374 (h) mortgage accident and health;
- 1375 (i) guaranteed automobile protection; and
- 1376 (j) another form of insurance offered in connection with an extension of credit that:
- 1377 (i) is limited to partially or wholly extinguishing the credit obligation; and
- 1378 (ii) the commissioner determines by rule should be designated as a form of limited line
- 1379 credit insurance.
- 1380 (113) "Limited line credit insurance producer" means a person who sells, solicits, or
- 1381 negotiates one or more forms of limited line credit insurance coverage to an individual through
- 1382 a master, corporate, group, or individual policy.
- 1383 (114) "Limited line insurance" includes:
- 1384 (a) bail bond;
- 1385 (b) limited line credit insurance;
- 1386 (c) legal expense insurance;
- 1387 (d) motor club insurance;
- 1388 (e) car rental related insurance;
- 1389 (f) travel insurance;

1390 (g) crop insurance;  
1391 (h) self-service storage insurance;  
1392 (i) guaranteed asset protection waiver;  
1393 (j) portable electronics insurance; and  
1394 (k) another form of limited insurance that the commissioner determines by rule should  
1395 be designated a form of limited line insurance.

1396 (115) "Limited lines authority" includes the lines of insurance listed in Subsection  
1397 (114).

1398 (116) "Limited lines producer" means a person who sells, solicits, or negotiates limited  
1399 lines insurance.

1400 (117) (a) "Long-term care insurance" means an insurance policy or rider advertised,  
1401 marketed, offered, or designated to provide coverage:

1402 (i) in a setting other than an acute care unit of a hospital;

1403 (ii) for not less than 12 consecutive months for a covered person on the basis of:

1404 (A) expenses incurred;

1405 (B) indemnity;

1406 (C) prepayment; or

1407 (D) another method;

1408 (iii) for one or more necessary or medically necessary services that are:

1409 (A) diagnostic;

1410 (B) preventative;

1411 (C) therapeutic;

1412 (D) rehabilitative;

1413 (E) maintenance; or

1414 (F) personal care; and

1415 (iv) that may be issued by:

1416 (A) an insurer;

1417 (B) a fraternal benefit society;

1418 (C) (I) a nonprofit health hospital; and

1419 (II) a medical service corporation;

1420 (D) a prepaid health plan;

- 1421 (E) a health maintenance organization; or
- 1422 (F) an entity similar to the entities described in Subsections (117)(a)(iv)(A) through (E)
- 1423 to the extent that the entity is otherwise authorized to issue life or health care insurance.
- 1424 (b) "Long-term care insurance" includes:
- 1425 (i) any of the following that provide directly or supplement long-term care insurance:
- 1426 (A) a group or individual annuity or rider; or
- 1427 (B) a life insurance policy or rider;
- 1428 (ii) a policy or rider that provides for payment of benefits on the basis of:
- 1429 (A) cognitive impairment; or
- 1430 (B) functional capacity; or
- 1431 (iii) a qualified long-term care insurance contract.
- 1432 (c) "Long-term care insurance" does not include:
- 1433 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
- 1434 (ii) basic hospital expense coverage;
- 1435 (iii) basic medical/surgical expense coverage;
- 1436 (iv) hospital confinement indemnity coverage;
- 1437 (v) major medical expense coverage;
- 1438 (vi) income replacement or related asset-protection coverage;
- 1439 (vii) accident only coverage;
- 1440 (viii) coverage for a specified:
- 1441 (A) disease; or
- 1442 (B) accident;
- 1443 (ix) limited benefit health coverage; or
- 1444 (x) a life insurance policy that accelerates the death benefit to provide the option of a
- 1445 lump sum payment:
- 1446 (A) if the following are not conditioned on the receipt of long-term care:
- 1447 (I) benefits; or
- 1448 (II) eligibility; and
- 1449 (B) the coverage is for one or more the following qualifying events:
- 1450 (I) terminal illness;
- 1451 (II) medical conditions requiring extraordinary medical intervention; or

- 1452 (III) permanent institutional confinement.
- 1453 (118) "Managed care organization" means a person:
- 1454 (a) licensed as a health maintenance organization under Chapter 8, Health Maintenance
- 1455 Organizations and Limited Health Plans; or
- 1456 (b) (i) licensed under:
- 1457 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
- 1458 (B) Chapter 7, Nonprofit Health Service Insurance Corporations; or
- 1459 (C) Chapter 14, Foreign Insurers; and
- 1460 (ii) that requires an enrollee to use, or offers incentives, including financial incentives,
- 1461 for an enrollee to use, network providers.
- 1462 (119) "Medical malpractice insurance" means insurance against legal liability incident
- 1463 to the practice and provision of a medical service other than the practice and provision of a
- 1464 dental service.
- 1465 (120) "Member" means a person having membership rights in an insurance
- 1466 corporation.
- 1467 (121) "Minimum capital" or "minimum required capital" means the capital that must be
- 1468 constantly maintained by a stock insurance corporation as required by statute.
- 1469 (122) "Mortgage accident and health insurance" means insurance offered in connection
- 1470 with an extension of credit that provides indemnity for payments coming due on a mortgage
- 1471 while the debtor has a disability.
- 1472 (123) "Mortgage guaranty insurance" means surety insurance under which a mortgagee
- 1473 or other creditor is indemnified against losses caused by the default of a debtor.
- 1474 (124) "Mortgage life insurance" means insurance on the life of a debtor in connection
- 1475 with an extension of credit that pays if the debtor dies.
- 1476 (125) "Motor club" means a person:
- 1477 (a) licensed under:
- 1478 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
- 1479 (ii) Chapter 11, Motor Clubs; or
- 1480 (iii) Chapter 14, Foreign Insurers; and
- 1481 (b) that promises for an advance consideration to provide for a stated period of time
- 1482 one or more:



- 1483 (i) legal services under Subsection 31A-11-102(1)(b);  
1484 (ii) bail services under Subsection 31A-11-102(1)(c); or  
1485 (iii) (A) trip reimbursement;  
1486 (B) towing services;  
1487 (C) emergency road services;  
1488 (D) stolen automobile services;  
1489 (E) a combination of the services listed in Subsections (125)(b)(iii)(A) through (D); or  
1490 (F) other services given in Subsections 31A-11-102(1)(b) through (f).  
1491 (126) "Mutual" means a mutual insurance corporation.  
1492 (127) "Network plan" means health care insurance:  
1493 (a) that is issued by an insurer; and  
1494 (b) under which the financing and delivery of medical care is provided, in whole or in  
1495 part, through a defined set of providers under contract with the insurer, including the financing  
1496 and delivery of an item paid for as medical care.  
1497 (128) "Network provider" means a health care provider who has an agreement with a  
1498 managed care organization to provide health care services to an enrollee with an expectation of  
1499 receiving payment, other than coinsurance, copayments, or deductibles, directly from the  
1500 managed care organization.  
1501 (129) "Nonparticipating" means a plan of insurance under which the insured is not  
1502 entitled to receive a dividend representing a share of the surplus of the insurer.  
1503 (130) "Ocean marine insurance" means insurance against loss of or damage to:  
1504 (a) ships or hulls of ships;  
1505 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,  
1506 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia  
1507 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;  
1508 (c) earnings such as freight, passage money, commissions, or profits derived from  
1509 transporting goods or people upon or across the oceans or inland waterways; or  
1510 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,  
1511 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons  
1512 in connection with maritime activity.  
1513 (131) "Order" means an order of the commissioner.

1514 (132) "ORSA guidance manual" means the current version of the Own Risk and  
1515 Solvency Assessment Guidance Manual developed and adopted by the National Association of  
1516 Insurance Commissioners and as amended from time to time.

1517 (133) "ORSA summary report" means a confidential high-level summary of an insurer  
1518 or insurance group's own risk and solvency assessment.

1519 (134) "Outline of coverage" means a summary that explains an accident and health  
1520 insurance policy.

1521 (135) "Own risk and solvency assessment" means an insurer or insurance group's  
1522 confidential internal assessment:

1523 (a) (i) of each material and relevant risk associated with the insurer or insurance group;

1524 (ii) of the insurer or insurance group's current business plan to support each risk  
1525 described in Subsection (135)(a)(i); and

1526 (iii) of the sufficiency of capital resources to support each risk described in Subsection  
1527 (135)(a)(i); and

1528 (b) that is appropriate to the nature, scale, and complexity of an insurer or insurance  
1529 group.

1530 (136) "Participating" means a plan of insurance under which the insured is entitled to  
1531 receive a dividend representing a share of the surplus of the insurer.

1532 (137) "Participation," as used in a health benefit plan, means a requirement relating to  
1533 the minimum percentage of eligible employees that must be enrolled in relation to the total  
1534 number of eligible employees of an employer reduced by each eligible employee who  
1535 voluntarily declines coverage under the plan because the employee:

1536 (a) has other group health care insurance coverage; or

1537 (b) receives:

1538 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social  
1539 Security Amendments of 1965; or

1540 (ii) another government health benefit.

1541 (138) "Person" includes:

1542 (a) an individual;

1543 (b) a partnership;

1544 (c) a corporation;

1545 (d) an incorporated or unincorporated association;

1546 (e) a joint stock company;

1547 (f) a trust;

1548 (g) a limited liability company;

1549 (h) a reciprocal;

1550 (i) a syndicate; or

1551 (j) another similar entity or combination of entities acting in concert.

1552 (139) "Personal lines insurance" means property and casualty insurance coverage sold

1553 for primarily noncommercial purposes to:

1554 (a) an individual; or

1555 (b) a family.

1556 (140) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec.

1557 1002(16)(B).

1558 (141) "Plan year" means:

1559 (a) the year that is designated as the plan year in:

1560 (i) the plan document of a group health plan; or

1561 (ii) a summary plan description of a group health plan;

1562 (b) if the plan document or summary plan description does not designate a plan year or

1563 there is no plan document or summary plan description:

1564 (i) the year used to determine deductibles or limits;

1565 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;

1566 or

1567 (iii) the employer's taxable year if:

1568 (A) the plan does not impose deductibles or limits on a yearly basis; and

1569 (B) (I) the plan is not insured; or

1570 (II) the insurance policy is not renewed on an annual basis; or

1571 (c) in a case not described in Subsection (141)(a) or (b), the calendar year.

1572 (142) (a) "Policy" means a document, including an attached endorsement or application

1573 that:

1574 (i) purports to be an enforceable contract; and

1575 (ii) memorializes in writing some or all of the terms of an insurance contract.

- 1576 (b) "Policy" includes a service contract issued by:
- 1577 (i) a motor club under Chapter 11, Motor Clubs;
- 1578 (ii) a service contract provided under Chapter 6a, Service Contracts; and
- 1579 (iii) a corporation licensed under:
- 1580 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
- 1581 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
- 1582 (c) "Policy" does not include:
- 1583 (i) a certificate under a group insurance contract; or
- 1584 (ii) a document that does not purport to have legal effect.
- 1585 (143) "Policyholder" means a person who controls a policy, binder, or oral contract by
- 1586 ownership, premium payment, or otherwise.
- 1587 (144) "Policy illustration" means a presentation or depiction that includes
- 1588 nonguaranteed elements of a policy of life insurance over a period of years.
- 1589 (145) "Policy summary" means a synopsis describing the elements of a life insurance
- 1590 policy.
- 1591 (146) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No.
- 1592 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
- 1593 related federal regulations and guidance.
- 1594 (147) "Preexisting condition," with respect to health care insurance:
- 1595 (a) means a condition that was present before the effective date of coverage, whether or
- 1596 not medical advice, diagnosis, care, or treatment was recommended or received before that day;
- 1597 and
- 1598 (b) does not include a condition indicated by genetic information unless an actual
- 1599 diagnosis of the condition by a physician has been made.
- 1600 (148) (a) "Premium" means the monetary consideration for an insurance policy.
- 1601 (b) "Premium" includes, however designated:
- 1602 (i) an assessment;
- 1603 (ii) a membership fee;
- 1604 (iii) a required contribution; or
- 1605 (iv) monetary consideration.
- 1606 (c) (i) "Premium" does not include consideration paid to a third party administrator for

1607 the third party administrator's services.

1608 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for  
1609 insurance on the risks administered by the third party administrator.

1610 (149) "Principal officers" for a corporation means the officers designated under  
1611 Subsection 31A-5-203(3).

1612 (150) "Proceeding" includes an action or special statutory proceeding.

1613 (151) "Professional liability insurance" means insurance against legal liability incident  
1614 to the practice of a profession and provision of a professional service.

1615 (152) (a) Except as provided in Subsection (152)(b), "property insurance" means  
1616 insurance against loss or damage to real or personal property of every kind and any interest in  
1617 that property:

1618 (i) from all hazards or causes; and

1619 (ii) against loss consequential upon the loss or damage including vehicle  
1620 comprehensive and vehicle physical damage coverages.

1621 (b) "Property insurance" does not include:

1622 (i) inland marine insurance; and

1623 (ii) ocean marine insurance.

1624 (153) "Qualified long-term care insurance contract" or "federally tax qualified  
1625 long-term care insurance contract" means:

1626 (a) an individual or group insurance contract that meets the requirements of Section  
1627 7702B(b), Internal Revenue Code; or

1628 (b) the portion of a life insurance contract that provides long-term care insurance:

1629 (i) (A) by rider; or

1630 (B) as a part of the contract; and

1631 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue  
1632 Code.

1633 (154) "Qualified United States financial institution" means an institution that:

1634 (a) is:

1635 (i) organized under the laws of the United States or any state; or

1636 (ii) in the case of a United States office of a foreign banking organization, licensed  
1637 under the laws of the United States or any state;

1638 (b) is regulated, supervised, and examined by a United States federal or state authority  
1639 having regulatory authority over a bank or trust company; and

1640 (c) meets the standards of financial condition and standing that are considered  
1641 necessary and appropriate to regulate the quality of a financial institution whose letters of credit  
1642 will be acceptable to the commissioner as determined by:

1643 (i) the commissioner by rule; or

1644 (ii) the Securities Valuation Office of the National Association of Insurance  
1645 Commissioners.

1646 (155) (a) "Rate" means:

1647 (i) the cost of a given unit of insurance; or

1648 (ii) for property or casualty insurance, that cost of insurance per exposure unit either  
1649 expressed as:

1650 (A) a single number; or

1651 (B) a pure premium rate, adjusted before the application of individual risk variations  
1652 based on loss or expense considerations to account for the treatment of:

1653 (I) expenses;

1654 (II) profit; and

1655 (III) individual insurer variation in loss experience.

1656 (b) "Rate" does not include a minimum premium.

1657 (156) (a) Except as provided in Subsection (156)(b), "rate service organization" means  
1658 a person who assists an insurer in rate making or filing by:

1659 (i) collecting, compiling, and furnishing loss or expense statistics;

1660 (ii) recommending, making, or filing rates or supplementary rate information; or

1661 (iii) advising about rate questions, except as an attorney giving legal advice.

1662 (b) "Rate service organization" does not mean:

1663 (i) an employee of an insurer;

1664 (ii) a single insurer or group of insurers under common control;

1665 (iii) a joint underwriting group; or

1666 (iv) an individual serving as an actuarial or legal consultant.

1667 (157) "Rating manual" means any of the following used to determine initial and  
1668 renewal policy premiums:

- 1669 (a) a manual of rates;
- 1670 (b) a classification;
- 1671 (c) a rate-related underwriting rule; and
- 1672 (d) a rating formula that describes steps, policies, and procedures for determining
- 1673 initial and renewal policy premiums.
- 1674 (158) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow,
- 1675 or give, directly or indirectly:
  - 1676 (i) a refund of premium or portion of premium;
  - 1677 (ii) a refund of commission or portion of commission;
  - 1678 (iii) a refund of all or a portion of a consultant fee; or
  - 1679 (iv) providing services or other benefits not specified in an insurance or annuity
  - 1680 contract.
- 1681 (b) "Rebate" does not include:
  - 1682 (i) a refund due to termination or changes in coverage;
  - 1683 (ii) a refund due to overcharges made in error by the licensee; or
  - 1684 (iii) savings or wellness benefits as provided in the contract by the licensee.
- 1685 (159) "Received by the department" means:
  - 1686 (a) the date delivered to and stamped received by the department, if delivered in
  - 1687 person;
  - 1688 (b) the post mark date, if delivered by mail;
  - 1689 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
  - 1690 (d) the received date recorded on an item delivered, if delivered by:
    - 1691 (i) facsimile;
    - 1692 (ii) email; or
    - 1693 (iii) another electronic method; or
    - 1694 (e) a date specified in:
      - 1695 (i) a statute;
      - 1696 (ii) a rule; or
      - 1697 (iii) an order.
  - 1698 (160) "Reciprocal" or "interinsurance exchange" means an unincorporated association
  - 1699 of persons:

1700 (a) operating through an attorney-in-fact common to all of the persons; and  
1701 (b) exchanging insurance contracts with one another that provide insurance coverage  
1702 on each other.

1703 (161) "Reinsurance" means an insurance transaction where an insurer, for  
1704 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to  
1705 reinsurance transactions, this title sometimes refers to:

1706 (a) the insurer transferring the risk as the "ceding insurer"; and

1707 (b) the insurer assuming the risk as the:

1708 (i) "assuming insurer"; or

1709 (ii) "assuming reinsurer."

1710 (162) "Reinsurer" means a person licensed in this state as an insurer with the authority  
1711 to assume reinsurance.

1712 (163) "Residential dwelling liability insurance" means insurance against liability  
1713 resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is  
1714 a detached single family residence or multifamily residence up to four units.

1715 (164) (a) "Retrocession" means reinsurance with another insurer of a liability assumed  
1716 under a reinsurance contract.

1717 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a  
1718 liability assumed under a reinsurance contract.

1719 (165) "Rider" means an endorsement to:

1720 (a) an insurance policy; or

1721 (b) an insurance certificate.

1722 (166) "Secondary medical condition" means a complication related to an exclusion  
1723 from coverage in accident and health insurance.

1724 (167) (a) "Security" means a:

1725 (i) note;

1726 (ii) stock;

1727 (iii) bond;

1728 (iv) debenture;

1729 (v) evidence of indebtedness;

1730 (vi) certificate of interest or participation in a profit-sharing agreement;



- 1731 (vii) collateral-trust certificate;
- 1732 (viii) preorganization certificate or subscription;
- 1733 (ix) transferable share;
- 1734 (x) investment contract;
- 1735 (xi) voting trust certificate;
- 1736 (xii) certificate of deposit for a security;
- 1737 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
- 1738 payments out of production under such a title or lease;
- 1739 (xiv) commodity contract or commodity option;
- 1740 (xv) certificate of interest or participation in, temporary or interim certificate for,
- 1741 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
- 1742 in Subsections (167)(a)(i) through (xiv); or
- 1743 (xvi) another interest or instrument commonly known as a security.
- 1744 (b) "Security" does not include:
- 1745 (i) any of the following under which an insurance company promises to pay money in a
- 1746 specific lump sum or periodically for life or some other specified period:
- 1747 (A) insurance;
- 1748 (B) an endowment policy; or
- 1749 (C) an annuity contract; or
- 1750 (ii) a burial certificate or burial contract.
- 1751 (168) "Securityholder" means a specified person who owns a security of a person,
- 1752 including:
- 1753 (a) common stock;
- 1754 (b) preferred stock;
- 1755 (c) debt obligations; and
- 1756 (d) any other security convertible into or evidencing the right of any of the items listed
- 1757 in this Subsection (168).
- 1758 (169) (a) "Self-insurance" means an arrangement under which a person provides for
- 1759 spreading its own risks by a systematic plan.
- 1760 (b) Except as provided in this Subsection (169), "self-insurance" does not include an
- 1761 arrangement under which a number of persons spread their risks among themselves.

- 1762 (c) "Self-insurance" includes:
- 1763 (i) an arrangement by which a governmental entity undertakes to indemnify an
- 1764 employee for liability arising out of the employee's employment; and
- 1765 (ii) an arrangement by which a person with a managed program of self-insurance and
- 1766 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
- 1767 employees for liability or risk that is related to the relationship or employment.
- 1768 (d) "Self-insurance" does not include an arrangement with an independent contractor.
- 1769 (170) "Sell" means to exchange a contract of insurance:
- 1770 (a) by any means;
- 1771 (b) for money or its equivalent; and
- 1772 (c) on behalf of an insurance company.
- 1773 (171) "Short-term care insurance" means an insurance policy or rider advertised,
- 1774 marketed, offered, or designed to provide coverage that is similar to long-term care insurance,
- 1775 but that provides coverage for less than 12 consecutive months for each covered person.
- 1776 (172) "Short-term [~~limited duration health~~], limited-duration insurance" means a health
- 1777 benefit product that:
- 1778 (a) after taking into account any renewals or extensions, has a total duration of no more
- 1779 than 36 months; and
- 1780 (b) has an expiration date specified in the contract that is less than 12 months after the
- 1781 original effective date of coverage under the health benefit product.
- 1782 (173) "Significant break in coverage" means a period of 63 consecutive days during
- 1783 each of which an individual does not have creditable coverage.
- 1784 (174) (a) "Small employer" means, in connection with a health benefit plan and with
- 1785 respect to a calendar year and to a plan year, an employer who:
- 1786 (i) (A) employed at least one but not more than 50 eligible employees on business days
- 1787 during the preceding calendar year; or
- 1788 (B) if the employer did not exist for the entirety of the preceding calendar year,
- 1789 reasonably expects to employ an average of at least one but not more than 50 eligible
- 1790 employees on business days during the current calendar year;
- 1791 (ii) employs at least one employee on the first day of the plan year; and
- 1792 (iii) for an employer who has common ownership with one or more other employers, is

1793 treated as a single employer under 26 U.S.C. Sec. 414(b), (c), (m), or (o).

1794 (b) "Small employer" does not include a sole proprietor that does not employ at least  
1795 one employee.

1796 (175) "Special enrollment period," in connection with a health benefit plan, has the  
1797 same meaning as provided in federal regulations adopted pursuant to the Health Insurance  
1798 Portability and Accountability Act.

1799 (176) (a) "Subsidiary" of a person means an affiliate controlled by that person either  
1800 directly or indirectly through one or more affiliates or intermediaries.

1801 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting  
1802 shares are owned by that person either alone or with its affiliates, except for the minimum  
1803 number of shares the law of the subsidiary's domicile requires to be owned by directors or  
1804 others.

1805 (177) Subject to Subsection (91)(b), "surety insurance" includes:

1806 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or  
1807 perform the principal's obligations to a creditor or other obligee;

1808 (b) bail bond insurance; and

1809 (c) fidelity insurance.

1810 (178) (a) "Surplus" means the excess of assets over the sum of paid-in capital and  
1811 liabilities.

1812 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is  
1813 designated by the insurer or organization as permanent.

1814 (ii) Sections [31A-5-211](#), [31A-7-201](#), [31A-8-209](#), [31A-9-209](#), and [31A-14-205](#) require  
1815 that insurers or organizations doing business in this state maintain specified minimum levels of  
1816 permanent surplus.

1817 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the  
1818 same as the minimum required capital requirement that applies to stock insurers.

1819 (c) "Excess surplus" means:

1820 (i) for a life insurer, accident and health insurer, health organization, or property and  
1821 casualty insurer as defined in Section [31A-17-601](#), the lesser of:

1822 (A) that amount of an insurer's or health organization's total adjusted capital that  
1823 exceeds the product of:

- 1824 (I) 2.5; and
- 1825 (II) the sum of the insurer's or health organization's minimum capital or permanent
- 1826 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
- 1827 (B) that amount of an insurer's or health organization's total adjusted capital that
- 1828 exceeds the product of:
- 1829 (I) 3.0; and
- 1830 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and
- 1831 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer
- 1832 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
- 1833 (A) 1.5; and
- 1834 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
- 1835 (179) "Third party administrator" or "administrator" means a person who collects
- 1836 charges or premiums from, or who, for consideration, adjusts or settles claims of residents of
- 1837 the state in connection with insurance coverage, annuities, or service insurance coverage,
- 1838 except:
- 1839 (a) a union on behalf of its members;
- 1840 (b) a person administering a:
- 1841 (i) pension plan subject to the federal Employee Retirement Income Security Act of
- 1842 1974;
- 1843 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
- 1844 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
- 1845 (c) an employer on behalf of the employer's employees or the employees of one or
- 1846 more of the subsidiary or affiliated corporations of the employer;
- 1847 (d) an insurer licensed under the following, but only for a line of insurance for which
- 1848 the insurer holds a license in this state:
- 1849 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
- 1850 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;
- 1851 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
- 1852 (iv) Chapter 9, Insurance Fraternal; or
- 1853 (v) Chapter 14, Foreign Insurers;
- 1854 (e) a person:

- 1855 (i) licensed or exempt from licensing under:  
1856 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and  
1857 Reinsurance Intermediaries; or  
1858 (B) Chapter 26, Insurance Adjusters; and  
1859 (ii) whose activities are limited to those authorized under the license the person holds  
1860 or for which the person is exempt; or  
1861 (f) an institution, bank, or financial institution:  
1862 (i) that is:  
1863 (A) an institution whose deposits and accounts are to any extent insured by a federal  
1864 deposit insurance agency, including the Federal Deposit Insurance Corporation or National  
1865 Credit Union Administration; or  
1866 (B) a bank or other financial institution that is subject to supervision or examination by  
1867 a federal or state banking authority; and  
1868 (ii) that does not adjust claims without a third party administrator license.  
1869 (180) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner  
1870 of real or personal property or the holder of liens or encumbrances on that property, or others  
1871 interested in the property against loss or damage suffered by reason of liens or encumbrances  
1872 upon, defects in, or the unmarketability of the title to the property, or invalidity or  
1873 unenforceability of any liens or encumbrances on the property.  
1874 (181) "Total adjusted capital" means the sum of an insurer's or health organization's  
1875 statutory capital and surplus as determined in accordance with:  
1876 (a) the statutory accounting applicable to the annual financial statements required to be  
1877 filed under Section [31A-4-113](#); and  
1878 (b) another item provided by the RBC instructions, as RBC instructions is defined in  
1879 Section [31A-17-601](#).  
1880 (182) (a) "Trustee" means "director" when referring to the board of directors of a  
1881 corporation.  
1882 (b) "Trustee," when used in reference to an employee welfare fund, means an  
1883 individual, firm, association, organization, joint stock company, or corporation, whether acting  
1884 individually or jointly and whether designated by that name or any other, that is charged with  
1885 or has the overall management of an employee welfare fund.

1886 (183) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer"

1887 means an insurer:

1888 (i) not holding a valid certificate of authority to do an insurance business in this state;

1889 or

1890 (ii) transacting business not authorized by a valid certificate.

1891 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1892 (i) holding a valid certificate of authority to do an insurance business in this state; and

1893 (ii) transacting business as authorized by a valid certificate.

1894 (184) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

1895 (185) "Vehicle liability insurance" means insurance against liability resulting from or  
1896 incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle  
1897 comprehensive or vehicle physical damage coverage under Subsection (152).

1898 (186) "Voting security" means a security with voting rights, and includes a security  
1899 convertible into a security with a voting right associated with the security.

1900 (187) "Waiting period" for a health benefit plan means the period that must pass before  
1901 coverage for an individual, who is otherwise eligible to enroll under the terms of the health  
1902 benefit plan, can become effective.

1903 (188) "Workers' compensation insurance" means:

1904 (a) insurance for indemnification of an employer against liability for compensation  
1905 based on:

1906 (i) a compensable accidental injury; and

1907 (ii) occupational disease disability;

1908 (b) employer's liability insurance incidental to workers' compensation insurance and  
1909 written in connection with workers' compensation insurance; and

1910 (c) insurance assuring to a person entitled to workers' compensation benefits the  
1911 compensation provided by law.

1912 Section 6. Section **31A-2-104** is amended to read:

1913 **31A-2-104. Other employees -- Insurance fraud investigators.**

1914 (1) The department shall employ [~~a chief examiner and such other~~] professional,  
1915 technical, and clerical employees as necessary to carry out the duties of the department.

1916 (2) An insurance fraud investigator employed [~~pursuant to~~] in accordance with

1917 Subsection (1) may as ~~[approved by]~~ the commissioner approves:

1918 (a) be designated a law enforcement officer, as defined in Section 53-13-103; and

1919 (b) be eligible for retirement benefits under the Public Safety Employee's Retirement  
1920 System.

1921 Section 7. Section 31A-2-110 is amended to read:

1922 **31A-2-110. Official seal and signature.**

1923 (1) (a) Any statutory or common-law requirement that an official seal be affixed is  
1924 satisfied by the signature of the commissioner.

1925 (b) However, the commissioner may adopt and use a seal bearing the words  
1926 "Commissioner of Insurance for Utah," an impression of which shall be filed with the Division  
1927 of Archives.

1928 (2) Any signature of the commissioner may be in ~~[facsimile]~~ a format that affixes an  
1929 exact copy of the signature, unless specifically required to be handwritten.

1930 Section 8. Section 31A-2-212 is amended to read:

1931 **31A-2-212. Miscellaneous duties.**

1932 (1) Upon issuance of an order limiting, suspending, or revoking a person's authority to  
1933 do business in Utah, and when the commissioner begins a proceeding against an insurer under  
1934 Chapter 27a, Insurer Receivership Act, the commissioner:

1935 (a) shall notify by mail the producers of the person or insurer of whom the  
1936 commissioner has record; and

1937 (b) may publish notice of the order or proceeding in any manner the commissioner  
1938 considers necessary to protect the rights of the public.

1939 (2) (a) When required for evidence in a legal proceeding, the commissioner shall  
1940 furnish a certificate of authority of a licensee to transact the business of insurance in Utah on  
1941 any particular date.

1942 (b) The court or other officer shall receive ~~[the]~~ a certificate of authority described in  
1943 this Subsection (2) in lieu of the commissioner's testimony.

1944 (3) (a) On the request of an insurer authorized to do a surety business, the  
1945 commissioner shall furnish a copy of the insurer's certificate of authority to a designated public  
1946 officer in this state who requires that certificate of authority before accepting a bond.

1947 (b) The public officer described in Subsection (3)(a) shall file the certificate of

1948 authority furnished under Subsection (3)(a).

1949 (c) After a certified copy of a certificate of authority is furnished to a public officer, it  
1950 is not necessary, while the certificate of authority remains effective, to attach a copy of it to any  
1951 instrument of suretyship filed with that public officer.

1952 (d) Whenever the commissioner revokes the certificate of authority or begins a  
1953 proceeding under Chapter 27a, Insurer Receivership Act, against an insurer authorized to do a  
1954 surety business, the commissioner shall immediately give notice of that action to each public  
1955 officer who is sent a certified copy under this Subsection (3).

1956 (4) (a) The commissioner shall immediately notify every judge and clerk of the courts  
1957 of record in the state when:

1958 (i) an authorized insurer doing a surety business:

1959 (A) files a petition for receivership; or

1960 (B) is in receivership; or

1961 (ii) the commissioner has reason to believe that the authorized insurer doing surety  
1962 business:

1963 (A) is in financial difficulty; or

1964 (B) has unreasonably failed to carry out any of ~~its~~ the authorized insurer's contracts.

1965 (b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the  
1966 judges and clerks to notify and require a person that files with the court a bond on which the  
1967 authorized insurer doing surety business is surety to immediately file a new bond with a new  
1968 surety.

1969 ~~[(5)(a) The commissioner shall report to the Legislature in accordance with Section~~  
1970 ~~63N-11-106 before adopting a rule authorized by Subsection (5)(b).]~~

1971 ~~[(b)]~~ (5)(a) The commissioner shall require an insurer that issues, sells, renews, or  
1972 offers health insurance coverage in this state to comply with PPACA and administrative rules  
1973 adopted by the commissioner related to regulation of health benefit plans, including:

1974 (i) lifetime and annual limits;

1975 (ii) prohibition of rescissions;

1976 (iii) coverage of preventive health services;

1977 (iv) coverage for a child or dependent;

1978 (v) pre-existing condition limitations;



- 1979 (vi) insurer transparency of consumer information including plan disclosures, uniform
- 1980 coverage documents, and standard definitions;
- 1981 (vii) premium rate reviews;
- 1982 (viii) essential health benefits;
- 1983 (ix) provider choice;
- 1984 (x) waiting periods;
- 1985 (xi) appeals processes;
- 1986 (xii) rating restrictions;
- 1987 (xiii) uniform applications and notice provisions;
- 1988 (xiv) certification and regulation of qualified health plans; and
- 1989 (xv) network adequacy standards.

1990 ~~[(e)]~~ (b) The commissioner shall preserve state control over:

- 1991 (i) the health insurance market in the state;
- 1992 (ii) qualified health plans offered in the state; and
- 1993 (iii) the conduct of navigators, producers, and in-person assisters operating in the state.

1994 ~~[(d) If the state enters into an agreement with the United States Department of Health~~

1995 ~~and Human Services in which the state operates health insurance plan management, the~~

1996 ~~commissioner may:]~~

1997 ~~[(i) for fiscal year 2014, hire one temporary and two permanent full-time employees to~~

1998 ~~be funded through the department's existing budget; and]~~

1999 ~~[(ii) for fiscal year 2015, hire two permanent full-time employees funded through the~~

2000 ~~Insurance Department Restricted Account, subject to appropriations from the Legislature and~~

2001 ~~approval by the governor.]~~

2002 Section 9. Section **31A-2-218** is amended to read:

2003 **31A-2-218. Strategic plan for health system reform.**

2004 The commissioner and the department shall:

2005 ~~[(1) work with the Governor's Office of Economic Development, the Department of~~

2006 ~~Health, the Department of Workforce Services, and the Legislature to develop health system~~

2007 ~~reform in accordance with the strategic plan described in Title 63N, Chapter 11, Health System~~

2008 ~~Reform Act;]~~

2009 ~~[(2) work with health insurers in accordance with Section [31A-22-635](#) to develop~~

2010 standards for health insurance applications and compatible electronic systems;]

2011 [~~(3)~~] (1) facilitate a private sector method for the collection of health insurance  
2012 premium payments made for a single policy by multiple payers, including the policyholder, one  
2013 or more employers of one or more individuals covered by the policy, government programs,  
2014 and others by educating employers and insurers about collection services available through  
2015 private vendors, including financial institutions;

2016 [~~(4)~~] (2) encourage health insurers to develop products that:

2017 (a) encourage health care providers to follow best practice protocols;

2018 (b) incorporate other health care quality improvement mechanisms; and

2019 (c) incorporate rewards and incentives for healthy lifestyles and behaviors as permitted  
2020 by the Health Insurance Portability and Accountability Act;

2021 [~~(5)~~] (3) involve the Office of Consumer Health Assistance created in Section  
2022 31A-2-216, as necessary, to accomplish the requirements of this section; and

2023 [~~(6)~~] (4) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking  
2024 Act, make rules, as necessary, to implement Subsections (1) and (2)[, ~~(3)~~, and ~~(4)~~].

2025 Section 10. Section 31A-2-309 is amended to read:

2026 **31A-2-309. Service of process through state officer.**

2027 (1) The commissioner, or the lieutenant governor when the subject proceeding is  
2028 brought by the state, is the agent for receipt of service of a summons, notice, order, pleading, or  
2029 other legal process relating to a Utah court or administrative agency upon the following:

2030 (a) an insurer authorized to do business in this state, while authorized to do business in  
2031 this state, and thereafter in a proceeding arising from or related to a transaction having a  
2032 connection with this state;

2033 (b) a surplus lines insurer for a proceeding arising out of a contract of insurance that is  
2034 subject to the surplus lines law, or out of a certificate, cover note, or other confirmation of that  
2035 type of insurance;

2036 (c) an unauthorized insurer or other person assisting an unauthorized insurer under  
2037 Subsection 31A-15-102(1) by doing an act specified in Subsection 31A-15-102(2), for a  
2038 proceeding arising out of a transaction that is subject to the unauthorized insurance law;

2039 (d) a nonresident producer, consultant, adjuster, or third party administrator, while  
2040 authorized to do business in this state, and thereafter in a proceeding arising from or related to

2041 a transaction having a connection with this state; and

2042 (e) a reinsurer submitting to the commissioner's jurisdiction under Subsection  
2043 31A-17-404~~(9)~~(11).

2044 (2) The following is considered to have irrevocably appointed the commissioner and  
2045 lieutenant governor as that person's agents in accordance with Subsection (1):

2046 (a) a licensed insurer by applying for and receiving a certificate of authority;

2047 (b) a surplus lines insurer by entering into a contract subject to the surplus lines law;

2048 (c) an unauthorized insurer by doing in this state an act prohibited by Section

2049 31A-15-103; and

2050 (d) a nonresident producer, consultant, adjuster, and third party administrator.

2051 (3) The commissioner and lieutenant governor are also agents for an executor,  
2052 administrator, personal representative, receiver, trustee, or other successor in interest of a  
2053 person specified under Subsection (1).

2054 (4) A litigant serving process on the commissioner or lieutenant governor under this  
2055 section shall pay the fee applicable under Section 31A-3-103.

2056 (5) The right to substituted service under this section does not limit the right to serve a  
2057 summons, notice, order, pleading, demand, or other process upon a person in another manner  
2058 provided by law.

2059 Section 11. Section 31A-2-403 is amended to read:

2060 **31A-2-403. Title and Escrow Commission created.**

2061 (1) (a) Subject to Subsection (1)(b), there is created within the department the Title and  
2062 Escrow Commission that is comprised of five members appointed by the governor with the  
2063 consent of the Senate as follows:

2064 (i) except as provided in Subsection ~~[(1)(e)]~~ (1)(d), two members shall be employees of  
2065 a title insurer;

2066 (ii) two members shall:

2067 (A) be employees of a Utah agency title insurance producer;

2068 (B) be or have been licensed under the title insurance line of authority;

2069 (C) as of the day on which the member is appointed, be or have been licensed with the  
2070 title examination or escrow subline of authority for at least five years; and

2071 (D) as of the day on which the member is appointed, not be from the same county as

2072 another member appointed under this Subsection (1)(a)(ii); and  
2073 (iii) one member shall be a member of the general public from any county in the state.

2074 (b) No more than one commission member may be appointed from a single company  
2075 or an affiliate or subsidiary of the company.

2076 (c) No more than two commission members may be employees of an entity operating  
2077 under an affiliated business arrangement, as defined in Section [31A-23a-1001](#).

2078 [~~e~~] (d) If the governor is unable to identify more than one individual who is an  
2079 employee of a title insurer and willing to serve as a member of the commission, the  
2080 commission shall include the following members in lieu of the members described in  
2081 Subsection (1)(a)(i):

- 2082 (i) one member who is an employee of a title insurer; and
- 2083 (ii) one member who is an employee of a Utah agency title insurance producer.

2084 (2) (a) Subject to Subsection (2)(c), a commission member shall file with the  
2085 commissioner a disclosure of any position of employment or ownership interest that the  
2086 commission member has with respect to a person that is subject to the jurisdiction of the  
2087 commissioner.

2088 (b) The disclosure statement required by this Subsection (2) shall be:

2089 (i) filed by no later than the day on which the person begins that person's appointment;  
2090 and

2091 (ii) amended when a significant change occurs in any matter required to be disclosed  
2092 under this Subsection (2).

2093 (c) A commission member is not required to disclose an ownership interest that the  
2094 commission member has if the ownership interest is in a publicly traded company or held as  
2095 part of a mutual fund, trust, or similar investment.

2096 (3) (a) Except as required by Subsection (3)(b), as terms of current commission  
2097 members expire, the governor shall appoint each new commission member to a four-year term  
2098 ending on June 30.

2099 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the  
2100 time of appointment, adjust the length of terms to ensure that the terms of the commission  
2101 members are staggered so that approximately half of the members appointed under Subsection  
2102 (1)(a)(i) and half of the members appointed under Subsection (1)(a)(ii) are appointed every two

2103 years.

2104 (c) A commission member may not serve more than one consecutive term.

2105 (d) When a vacancy occurs in the membership for any reason, the governor, with the  
2106 consent of the Senate, shall appoint a replacement for the unexpired term.

2107 (e) Notwithstanding the other provisions of this Subsection (3), a commission member  
2108 serves until a successor is appointed by the governor with the consent of the Senate.

2109 (4) A commission member may not receive compensation or benefits for the  
2110 commission member's service, but may receive per diem and travel expenses in accordance  
2111 with:

2112 (a) Section [63A-3-106](#);

2113 (b) Section [63A-3-107](#); and

2114 (c) rules made by the Division of Finance pursuant to Sections [63A-3-106](#) and  
2115 [63A-3-107](#).

2116 (5) Members of the commission shall annually select one commission member to serve  
2117 as chair.

2118 (6) (a) (i) Except as provided in Subsection (6)(b), the commission shall meet at least  
2119 monthly.

2120 (ii) (A) The commissioner shall, with the concurrence of the chair of the commission,  
2121 designate at least one monthly meeting per quarter as an in-person meeting.

2122 (B) Notwithstanding Section [52-4-207](#), a commission member shall physically attend a  
2123 meeting designated as an in-person meeting under Subsection (6)(a)(ii)(A) and may not attend  
2124 through electronic means. A commission member may attend any other commission meeting,  
2125 subcommittee meeting, or emergency meeting by electronic means in accordance with Section  
2126 [52-4-207](#).

2127 (b) (i) Except as provided in Subsection (6)(b)(ii), the commissioner may, with the  
2128 concurrence of the chair of the commission, cancel a monthly meeting of the commission if,  
2129 due to the number or nature of pending title insurance matters, the monthly meeting is not  
2130 necessary.

2131 (ii) The commissioner may not cancel a monthly meeting designated as an in-person  
2132 meeting under Subsection (6)(a)(ii)(A).

2133 (c) The commissioner may call additional meetings:

- 2134 (i) at the commissioner's discretion;
- 2135 (ii) upon the request of the chair of the commission; or
- 2136 (iii) upon the written request of three or more commission members.
- 2137 (d) (i) Three commission members constitute a quorum for the transaction of business.
- 2138 (ii) The action of a majority of the commission members when a quorum is present is
- 2139 the action of the commission.

2140 (7) The commissioner shall staff the commission.

2141 Section 12. Section **31A-6a-101** is amended to read:

2142 **31A-6a-101. Definitions.**

2143 As used in this chapter:

2144 (1) "Home warranty service contract" means a service contract that requires a person to  
2145 repair or replace a component, system, or appliance of a home or make indemnification to the  
2146 contract holder for the repair or replacement of a component, system, or appliance of the home:

2147 (a) upon mechanical or operational failure of the component, system, or appliance;

2148 (b) for a predetermined fee; and

2149 (c) if:

2150 (i) the person is not the builder, seller, or lessor of the home that is the subject of the  
2151 contract; and

2152 (ii) the failure described in Subsection (1)(a) occurs within a specified period of time.

2153 [~~(1)~~] (2) (a) "Incidental cost" means a cost, incurred by a warranty holder in relation to  
2154 a vehicle protection product warranty, that is in addition to the cost of purchasing the warranty.

2155 (b) "Incidental cost" includes an insurance policy deductible, a rental vehicle charge,  
2156 the difference between the actual value of the stolen vehicle at the time of theft and the cost of  
2157 a replacement vehicle, sales tax, a registration fee, a transaction fee, a mechanical inspection  
2158 fee, or damage a theft causes to a vehicle.

2159 [~~(2)~~] (3) "Mechanical breakdown insurance" means a policy, contract, or agreement  
2160 issued by an insurance company that has complied with either Chapter 5, Domestic Stock and  
2161 Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, that undertakes to perform or  
2162 provide repair or replacement service on goods or property, or indemnification for repair or  
2163 replacement service, for the operational or structural failure of the goods or property due to a  
2164 defect in materials, workmanship, or normal wear and tear.

2165            [~~(3)~~] (4) "Nonmanufacturers' parts" means replacement parts not made for or by the  
2166 original manufacturer of the goods commonly referred to as "after market parts."

2167            [~~(4)~~] (5) (a) "Road hazard" means a hazard that is encountered while driving a motor  
2168 vehicle.

2169            (b) "Road hazard" includes potholes, rocks, wood debris, metal parts, glass, plastic,  
2170 curbs, or composite scraps.

2171            [~~(5)~~] (6) (a) "Service contract" means a contract or agreement to perform or reimburse  
2172 for the repair or maintenance of goods or property, for their operational or structural failure due  
2173 to a defect in materials, workmanship, normal wear and tear, power surge or interruption, or  
2174 accidental damage from handling, with or without additional provision for incidental payment  
2175 of indemnity under limited circumstances, including towing, providing a rental car, providing  
2176 emergency road service, and covering food spoilage.

2177            (b) "Service contract" does not include:

2178            (i) mechanical breakdown insurance; or

2179            (ii) a prepaid contract of limited duration that provides for scheduled maintenance  
2180 only, regardless of whether the contract is executed before, on, or after May 9, 2017.

2181            (c) "Service contract" includes any contract or agreement to perform or reimburse the  
2182 service contract holder for any one or more of the following services:

2183            (i) the repair or replacement of tires, wheels, or both on a motor vehicle damaged as a  
2184 result of coming into contact with a road hazard;

2185            (ii) the removal of dents, dings, or creases on a motor vehicle that can be repaired using  
2186 the process of paintless dent removal without affecting the existing paint finish and without  
2187 replacing vehicle body panels, sanding, bonding, or painting;

2188            (iii) the repair of chips or cracks in or the replacement of a motor vehicle windshield as  
2189 a result of damage caused by a road hazard, that is primary to the coverage offered by the motor  
2190 vehicle owner's motor vehicle insurance policy; or

2191            (iv) the replacement of a motor vehicle key or key-fob if the key or key-fob becomes  
2192 inoperable, lost, or stolen, except that the replacement of lost or stolen property is limited to  
2193 only the replacement of a lost or stolen motor vehicle key or key-fob.

2194            [~~(6)~~] (7) "Service contract holder" or "contract holder" means a person who purchases a  
2195 service contract.

2196            [~~(7)~~] (8) "Service contract provider" means a person who issues, makes, provides,  
2197 administers, sells or offers to sell a service contract, or who is contractually obligated to  
2198 provide service under a service contract.

2199            [~~(8)~~] (9) "Service contract reimbursement policy" or "reimbursement insurance policy"  
2200 means a policy of insurance providing coverage for all obligations and liabilities incurred by  
2201 the service contract provider or warrantor under the terms of the service contract or vehicle  
2202 protection product warranty issued by the provider or warrantor.

2203            [~~(9)~~] (10) (a) "Vehicle protection product" means a device or system that is:

- 2204            (i) installed on or applied to a motor vehicle; and
- 2205            (ii) designed to:
  - 2206            (A) prevent the theft of the vehicle; or
  - 2207            (B) if the vehicle is stolen, aid in the recovery of the vehicle.

2208            (b) "Vehicle protection product" includes:

- 2209            (i) a vehicle protection product warranty;
- 2210            (ii) an alarm system;
- 2211            (iii) a body part marking product;
- 2212            (iv) a steering lock;
- 2213            (v) a window etch product;
- 2214            (vi) a pedal and ignition lock;
- 2215            (vii) a fuel and ignition kill switch; and
- 2216            (viii) an electronic, radio, or satellite tracking device.

2217            [~~(10)~~] (11) "Vehicle protection product warranty" means a written agreement by a  
2218 warrantor that provides that if the vehicle protection product fails to prevent the theft of the  
2219 motor vehicle, or aid in the recovery of the motor vehicle within a time period specified in the  
2220 warranty, not exceeding 30 days after the day on which the motor vehicle is reported stolen, the  
2221 warrantor will reimburse the warranty holder for incidental costs specified in the warranty, not  
2222 exceeding \$5,000, or in a specified fixed amount not exceeding \$5,000.

2223            (12) "Vehicle service contract" means a service contract for the repair or maintenance  
2224 of a vehicle:

2225            (a) for operational or structural failure because of a defect in materials, workmanship,  
2226 normal wear and tear, or accidental damage from handling; and



2227 (b) with or without additional provision for incidental payment of indemnity under  
2228 limited circumstances, including towing, providing a rental car, or providing emergency road  
2229 service.

2230 [~~(11)~~] (13) "Warrantor" means a person who is contractually obligated to the warranty  
2231 holder under the terms of a vehicle protection product warranty.

2232 [~~(12)~~] (14) "Warranty holder" means the person who purchases a vehicle protection  
2233 product, any authorized transferee or assignee of the purchaser, or any other person legally  
2234 assuming the purchaser's rights under the vehicle protection product warranty.

2235 Section 13. Section **31A-6a-103** is amended to read:

2236 **31A-6a-103. Requirements for doing business.**

2237 (1) A service contract or vehicle protection product warranty may not be issued, sold,  
2238 or offered for sale in this state unless the service contract or vehicle protection product  
2239 warranty is insured under a reimbursement insurance policy issued by:

2240 (a) an insurer authorized to do business in this state; or

2241 (b) a recognized surplus lines carrier.

2242 (2) (a) A service contract or vehicle protection product warranty may not be issued,  
2243 sold, or offered for sale unless the service contract provider or warrantor completes the  
2244 registration process described in this Subsection (2).

2245 (b) To register, a service contract provider or warrantor shall submit to the department  
2246 the following:

2247 (i) an application for registration;

2248 (ii) a fee established in accordance with Section [31A-3-103](#);

2249 (iii) a copy of any service contract or vehicle protection product warranty that the  
2250 service contract provider or warrantor offers in this state; and

2251 (iv) a copy of the service contract provider's or warrantor's reimbursement insurance  
2252 policy.

2253 (c) A service provider or warrantor shall submit the information described in  
2254 Subsection (2)(b) no less than 30 days before the day on which the service provider or  
2255 warrantor issues, sells, offers for sale, or uses a service contract, vehicle protection product  
2256 warranty, or reimbursement insurance policy in this state.

2257 (d) A service provider or warrantor shall file any modification of the terms of a service

2258 contract, vehicle protection product warranty, or reimbursement insurance policy 30 days  
2259 before the day on which it is used in this state.

2260 (e) A person complying with this chapter is not required to comply with:

2261 (i) Subsections [31A-21-201\(1\)](#) and [31A-23a-402\(3\)](#); or

2262 (ii) Chapter 19a, Utah Rate Regulation Act.

2263 (f) (i) Each year before March 1, a service provider shall pay an annual registration fee  
2264 established in accordance with Section [31A-3-103](#).

2265 (ii) If a service provider does not pay the annual registration fee described in this  
2266 Subsection (2)(f) before March 1:

2267 (A) the service provider's registration is expired; and

2268 (B) the service provider may apply for registration in accordance with this Subsection  
2269 (2).

2270 (3) (a) Premiums collected on a service contract are not subject to premium taxes.

2271 (b) Premiums collected by an issuer of a reimbursement insurance policy are subject to  
2272 premium taxes.

2273 (4) A person marketing, selling, or offering to sell a service contract or vehicle  
2274 protection product warranty for a service contract provider or warrantor that complies with this  
2275 chapter is exempt from the licensing requirements of this title.

2276 (5) A service contract provider or warrantor complying with this chapter is not required  
2277 to comply with:

2278 (a) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

2279 (b) Chapter 7, Nonprofit Health Service Insurance Corporations;

2280 (c) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

2281 (d) Chapter 9, Insurance Fraternal;

2282 (e) Chapter 10, Annuities;

2283 (f) Chapter 11, Motor Clubs;

2284 (g) Chapter 12, State Risk Management Fund;

2285 (h) Chapter 14, Foreign Insurers;

2286 (i) Chapter 19a, Utah Rate Regulation Act;

2287 (j) Chapter 25, Third Party Administrators; and

2288 (k) Chapter 28, Guaranty Associations.

2289 Section 14. Section **31A-6a-104** is amended to read:

2290 **31A-6a-104. Required disclosures.**

2291 (1) A reimbursement insurance policy insuring a service contract or a vehicle  
2292 protection product warranty that is issued, sold, or offered for sale in this state shall  
2293 conspicuously state that, upon failure of the service contract provider or warrantor to perform  
2294 under the contract, the issuer of the policy shall:

2295 (a) pay on behalf of the service contract provider or warrantor any sums the service  
2296 contract provider or warrantor is legally obligated to pay according to the service contract  
2297 provider's or warrantor's contractual obligations under the service contract or a vehicle  
2298 protection product warranty issued or sold by the service contract provider or warrantor; or

2299 (b) provide the service which the service contract provider is legally obligated to  
2300 perform, according to the service contract provider's contractual obligations under the service  
2301 contract issued or sold by the service contract provider.

2302 (2) (a) A service contract may not be issued, sold, or offered for sale in this state unless  
2303 the service contract contains the following statements in substantially the following form:

2304 (i) "Obligations of the provider under this service contract are guaranteed under a  
2305 service contract reimbursement insurance policy. Should the provider fail to pay or provide  
2306 service on any claim within 60 days after proof of loss has been filed, the contract holder is  
2307 entitled to make a claim directly against the Insurance Company.";

2308 (ii) "This service contract or warranty is subject to limited regulation by the Utah  
2309 Insurance Department. To file a complaint, contact the Utah Insurance Department."; and

2310 (iii) A service contract or reimbursement insurance policy may not be issued, sold, or  
2311 offered for sale in this state unless the contract contains a statement in substantially the  
2312 following form, "Coverage afforded under this contract is not guaranteed by the Property and  
2313 Casualty Guaranty Association."

2314 (b) A vehicle protection product warranty may not be issued, sold, or offered for sale in  
2315 this state unless the vehicle protection product warranty contains the following statements in  
2316 substantially the following form:

2317 (i) "Obligations of the warrantor under this vehicle protection product warranty are  
2318 guaranteed under a reimbursement insurance policy. Should the warrantor fail to pay on any  
2319 claim within 60 days after proof of loss has been filed, the warranty holder is entitled to make a

2320 claim directly against the Insurance Company.";

2321 (ii) "This vehicle protection product warranty is subject to limited regulation by the  
2322 Utah Insurance Department. To file a complaint, contact the Utah Insurance Department."; and

2323 (iii) as applicable:

2324 (A) "The warrantor under this vehicle protection product warranty will reimburse the  
2325 warranty holder as specified in the warranty upon the theft of the vehicle."; or

2326 (B) "The warrantor under this vehicle protection product warranty will reimburse the  
2327 warranty holder as specified in the warranty and at the end of the time period specified in the  
2328 warranty if, following the theft of the vehicle, the stolen vehicle is not recovered within a time  
2329 period specified in the warranty, not to exceed 30 days after the day on which the vehicle is  
2330 reported stolen."

2331 (c) A vehicle protection product warranty, or reimbursement insurance policy, may not  
2332 be issued, sold, or offered for sale in this state unless the warranty contains a statement in  
2333 substantially the following form, "Coverage afforded under this warranty is not guaranteed by  
2334 the Property and Casualty Guaranty Association."

2335 (3) A service contract and a vehicle protection product warranty shall:

2336 (a) conspicuously state the name, address, and a toll free claims service telephone  
2337 number of the reimbursement insurer;

2338 (b) (i) identify the service contract provider, the seller, and the service contract holder;  
2339 or

2340 (ii) identify the warrantor, the seller, and the warranty holder;

2341 (c) conspicuously state the total purchase price and the terms under which the service  
2342 contract or warranty is to be paid;

2343 (d) conspicuously state the existence of any deductible amount;

2344 (e) specify the merchandise, service to be provided, and any limitation, exception, or  
2345 exclusion;

2346 (f) state a term, restriction, or condition governing the transferability of the service  
2347 contract or warranty; and

2348 (g) state a term, restriction, or condition that governs cancellation of the service  
2349 contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder  
2350 or service contract provider.

2351 (4) If prior approval of repair work is required~~[, a service]~~ under a home protection  
2352 service contract or a vehicle service contract, the contract shall conspicuously state the  
2353 procedure for obtaining prior approval and for making a claim, including:

2354 (a) a toll free telephone number for claim service; and

2355 (b) a procedure for obtaining reimbursement for emergency repairs performed outside  
2356 of normal business hours.

2357 (5) A preexisting condition clause in a service contract shall specifically state which  
2358 preexisting condition is excluded from coverage.

2359 (6) (a) Except as provided in Subsection (6)(c), a service contract shall state the  
2360 conditions upon which the use of a nonmanufacturers' part is allowed.

2361 (b) A condition described in Subsection (6)(a) shall comply with applicable state and  
2362 federal laws.

2363 (c) This Subsection (6) does not apply to:

2364 (i) a home warranty service contract~~[;]~~; or

2365 (ii) a service contract that does not impose an obligation to provide parts.

2366 (7) This section applies to a vehicle protection product warranty, except for the  
2367 requirements of Subsections (3)(d) and (g), (4), (5), and (6). The department may make rules  
2368 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement  
2369 the application of this section to a vehicle protection product warranty.

2370 (8) (a) As used in this Subsection (8), "conspicuous statement" means a disclosure that:

2371 (i) appears in all-caps, bold, and 14-point font; and

2372 (ii) provides a space to be initialed by the consumer:

2373 (A) immediately below the printed disclosure; and

2374 (B) at or before the time the consumer purchases the vehicle protection product.

2375 (b) (i) A vehicle protection product warranty shall contain a conspicuous statement in  
2376 substantially the following form: "Purchase of this product is optional and is not required in  
2377 order to finance, lease, or purchase a motor vehicle."

2378 (ii) Beginning January 1, 2021, a service contract shall contain a conspicuous statement  
2379 in substantially the following form: "Purchase of this product is optional and is not required in  
2380 order to finance, lease, or purchase a motor vehicle."

2381 (9) If a vehicle protection product warranty states that the warrantor will reimburse the

2382 warranty holder for incidental costs, the vehicle protection product warranty shall state how  
2383 incidental costs paid under the warranty are calculated.

2384 (10) If a vehicle protection product warranty states that the warrantor will reimburse  
2385 the warranty holder in a fixed amount, the vehicle protection product warranty shall state the  
2386 fixed amount.

2387 Section 15. Section **31A-8-211** is amended to read:

2388 **31A-8-211. Deposit.**

2389 (1) Except as provided in Subsection (2), each health maintenance organization  
2390 authorized in this state shall maintain a deposit with the commissioner under Section  
2391 **31A-2-206** in an amount equal to the sum of:

2392 (a) \$100,000; and

2393 (b) 50% of the greater of:

2394 (i) \$900,000;

2395 (ii) 2% of the annual premium revenues as reported on the most recent annual financial  
2396 statement filed with the commissioner; or

2397 (iii) an amount equal to the sum of three months uncovered health care expenditures as  
2398 reported on the most recent financial statement filed with the commissioner.

2399 (2) (a) ~~[After a hearing the]~~ The commissioner may exempt a health maintenance  
2400 organization from the deposit requirement of Subsection (1) if:

2401 (i) the commissioner determines that the enrollees' interests are adequately protected;

2402 (ii) the health maintenance organization has been continuously authorized to do  
2403 business in this state for at least five years; and

2404 (iii) the health maintenance organization has \$5,000,000 surplus in excess of the health  
2405 maintenance organization's company action level RBC as defined in Subsection

2406 **31A-17-601(8)(b)**.

2407 (b) The commissioner may rescind an exemption given under Subsection (2)(a).

2408 (3) (a) Each limited health plan authorized in this state shall maintain a deposit with  
2409 the commissioner under Section **31A-2-206** in an amount equal to the minimum capital or  
2410 permanent surplus plus 50% of the greater of:

2411 (i) .5 times minimum required capital or minimum permanent surplus; or

2412 (ii) (A) during the first year of operation, 10% of the limited health plan's projected

2413 uncovered expenditures for the first year of operation;

2414 (B) during the second year of operation, 12% of the limited health plan's projected  
2415 uncovered expenditures for the second year of operation;

2416 (C) during the third year of operation, 14% of the limited health plan's projected  
2417 uncovered expenditures for the third year of operation;

2418 (D) during the fourth year of operation, 18% of the limited health plan's projected  
2419 uncovered expenditures during the fourth year of operation; or

2420 (E) during the fifth year of operation, and during all subsequent years, 20% of the  
2421 limited health plan's projected uncovered expenditures for the previous 12 months.

2422 (b) Projections of future uncovered expenditures shall be established in a manner that  
2423 is approved by the commissioner.

2424 (4) A deposit required by this section may be counted toward the minimum capital or  
2425 minimum permanent surplus required under Section [31A-8-209](#).

2426 Section 16. Section **31A-17-404** is amended to read:

2427 **31A-17-404. Credit allowed a domestic ceding insurer against reserves for**  
2428 **reinsurance.**

2429 (1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a  
2430 reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of  
2431 Subsection (3), (4), (5), (6), (7), ~~(8)~~, or (9) subject to the following:

2432 (a) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a  
2433 kind or class of business that the assuming insurer is licensed or otherwise permitted to write or  
2434 assume:

2435 (i) in its state of domicile; or

2436 (ii) in the case of a United States branch of an alien assuming insurer, in the state  
2437 through which it is entered and licensed to transact insurance or reinsurance.

2438 (b) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of  
2439 Subsection ~~(9)~~ (11) are met.

2440 (2) A domestic ceding insurer is allowed credit for reinsurance ceded:

2441 (a) only if the reinsurance is payable in a manner consistent with Section [31A-22-1201](#);

2442 (b) only to the extent that the accounting:

2443 (i) is consistent with the terms of the reinsurance contract; and

- 2444 (ii) clearly reflects:
- 2445 (A) the amount and nature of risk transferred; and
- 2446 (B) liability, including contingent liability, of the ceding insurer;
- 2447 (c) only to the extent the reinsurance contract shifts insurance policy risk from the
- 2448 ceding insurer to the assuming reinsurer in fact and not merely in form; and
- 2449 (d) only if the reinsurance contract contains a provision placing on the reinsurer the
- 2450 credit risk of all dealings with intermediaries regarding the reinsurance contract.
- 2451 (3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
- 2452 assuming insurer that is licensed to transact insurance or reinsurance in this state.
- 2453 (4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
- 2454 assuming insurer that is accredited by the commissioner as a reinsurer in this state.
- 2455 (b) An insurer is accredited as a reinsurer if the insurer:
- 2456 (i) files with the commissioner evidence of the insurer's submission to this state's
- 2457 jurisdiction;
- 2458 (ii) submits to the commissioner's authority to examine the insurer's books and records;
- 2459 (iii) (A) is licensed to transact insurance or reinsurance in at least one state; or
- 2460 (B) in the case of a United States branch of an alien assuming insurer, is entered
- 2461 through and licensed to transact insurance or reinsurance in at least one state;
- 2462 (iv) files annually with the commissioner a copy of the insurer's:
- 2463 (A) annual statement filed with the insurance department of its state of domicile; and
- 2464 (B) most recent audited financial statement; and
- 2465 (v) (A) (I) has not had its accreditation denied by the commissioner within 90 days ~~of~~
- 2466 after the day on which the insurer submits the information required by this Subsection (4); and
- 2467 (II) maintains a surplus with regard to policyholders in an amount not less than
- 2468 \$20,000,000; or
- 2469 (B) (I) has its accreditation approved by the commissioner; and
- 2470 (II) maintains a surplus with regard to policyholders in an amount less than
- 2471 \$20,000,000.
- 2472 (c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's
- 2473 accreditation is revoked by the commissioner after a notice and hearing.
- 2474 (5) (a) A domestic ceding insurer is allowed a credit if:



- 2475 (i) the reinsurance is ceded to an assuming insurer that is:
- 2476 (A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or
- 2477 (B) in the case of a United States branch of an alien assuming insurer, is entered
- 2478 through a state meeting the requirements of Subsection (5)(a)(ii);
- 2479 (ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for
- 2480 reinsurance substantially similar to those applicable under this section; and
- 2481 (iii) the assuming insurer or United States branch of an alien assuming insurer:
- 2482 (A) maintains a surplus with regard to policyholders in an amount not less than
- 2483 \$20,000,000; and
- 2484 (B) submits to the authority of the commissioner to examine its books and records.
- 2485 (b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded
- 2486 and assumed pursuant to a pooling arrangement among insurers in the same holding company
- 2487 system.
- 2488 (6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
- 2489 assuming insurer that maintains a trust fund:
- 2490 (i) created in accordance with rules made by the commissioner pursuant to Title 63G,
- 2491 Chapter 3, Utah Administrative Rulemaking Act; and
- 2492 (ii) in a qualified United States financial institution for the payment of a valid claim of:
- 2493 (A) a United States ceding insurer of the assuming insurer;
- 2494 (B) an assign of the United States ceding insurer; and
- 2495 (C) a successor in interest to the United States ceding insurer.
- 2496 (b) To enable the commissioner to determine the sufficiency of the trust fund described
- 2497 in Subsection (6)(a), the assuming insurer shall:
- 2498 (i) report annually to the commissioner information substantially the same as that
- 2499 required to be reported on the National Association of Insurance Commissioners Annual
- 2500 Statement form by a licensed insurer; and
- 2501 (ii) (A) submit to examination of its books and records by the commissioner; and
- 2502 (B) pay the cost of an examination.
- 2503 (c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the
- 2504 form of the trust and any amendment to the trust is approved by:
- 2505 (A) the commissioner of the state where the trust is domiciled; or

2506 (B) the commissioner of another state who, pursuant to the terms of the trust  
2507 instrument, accepts principal regulatory oversight of the trust.

2508 (ii) The form of the trust and an amendment to the trust shall be filed with the  
2509 commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.

2510 (iii) The trust instrument shall provide that a contested claim is valid and enforceable  
2511 upon the final order of a court of competent jurisdiction in the United States.

2512 (iv) The trust shall vest legal title to its assets in its one or more trustees for the benefit  
2513 of:

2514 (A) a United States ceding insurer of the assuming insurer;  
2515 (B) an assign of the United States ceding insurer; or  
2516 (C) a successor in interest to the United States ceding insurer.

2517 (v) The trust and the assuming insurer are subject to examination as determined by the  
2518 commissioner.

2519 (vi) The trust shall remain in effect for as long as the assuming insurer has an  
2520 outstanding obligation due under a reinsurance agreement subject to the trust.

2521 (vii) No later than February 28 of each year, the trustee of the trust shall:  
2522 (A) report to the commissioner in writing the balance of the trust;  
2523 (B) list the trust's investments at the end of the preceding calendar year; and  
2524 (C) (I) certify the date of termination of the trust, if so planned; or  
2525 (II) certify that the trust will not expire [~~prior to~~] before the following December 31.

2526 (d) The following requirements apply to the following categories of assuming insurer:  
2527 (i) For a single assuming insurer:  
2528 (A) the trust fund shall consist of funds in trust in an amount not less than the assuming  
2529 insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and  
2530 (B) the assuming insurer shall maintain a trusteed surplus of not less than \$20,000,000,  
2531 except as provided in Subsection (6)(d)(ii).

2532 (ii) (A) At any time after the assuming insurer has permanently discontinued  
2533 underwriting new business secured by the trust for at least three full years, the commissioner  
2534 with principal regulatory oversight of the trust may authorize a reduction in the required  
2535 trusteed surplus, but only after a finding, based on an assessment of the risk, that the new  
2536 required surplus level is adequate for the protection of United States ceding insurers,

2537 policyholders, and claimants in light of reasonably foreseeable adverse loss development.

2538 (B) The risk assessment may involve an actuarial review, including an independent  
2539 analysis of reserves and cash flows, and shall consider all material risk factors, including, when  
2540 applicable, the lines of business involved, the stability of the incurred loss estimates, and the  
2541 effect of the surplus requirements on the assuming insurer's liquidity or solvency.

2542 (C) The minimum required trusteed surplus may not be reduced to an amount less than  
2543 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States  
2544 ceding insurers covered by the trust.

2545 (iii) For a group acting as assuming insurer, including incorporated and individual  
2546 unincorporated underwriters:

2547 (A) for reinsurance ceded under a reinsurance agreement with an inception,  
2548 amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed  
2549 account in an amount not less than the respective underwriters' several liabilities attributable to  
2550 business ceded by the one or more United States domiciled ceding insurers to an underwriter of  
2551 the group;

2552 (B) for reinsurance ceded under a reinsurance agreement with an inception date on or  
2553 before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the  
2554 other provisions of this chapter, the trust shall consist of a trusteed account in an amount not  
2555 less than the respective underwriters' several insurance and reinsurance liabilities attributable to  
2556 business written in the United States;

2557 (C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall  
2558 maintain in trust a trusteed surplus of which \$100,000,000 is held jointly for the benefit of the  
2559 one or more United States domiciled ceding insurers of a member of the group for all years of  
2560 account;

2561 (D) the incorporated members of the group:

2562 (I) may not be engaged in a business other than underwriting as a member of the group;  
2563 and

2564 (II) are subject to the same level of regulation and solvency control by the group's  
2565 domiciliary regulator as are the unincorporated members; and

2566 (E) within 90 days after the day on which the group's financial statements are due to be  
2567 filed with the group's domiciliary regulator, the group shall provide to the commissioner:

2568 (I) an annual certification by the group's domiciliary regulator of the solvency of each  
2569 underwriter member; or

2570 (II) if a certification is unavailable, a financial statement, prepared by an independent  
2571 public accountant, of each underwriter member of the group.

2572 (iv) For a group of incorporated underwriters under common administration, the group  
2573 shall:

2574 (A) have continuously transacted an insurance business outside the United States for at  
2575 least three years immediately preceding the day on which the group makes application for  
2576 accreditation;

2577 (B) maintain aggregate policyholders' surplus of at least \$10,000,000,000;

2578 (C) maintain a trust fund in an amount not less than the group's several liabilities  
2579 attributable to business ceded by the one or more United States domiciled ceding insurers to a  
2580 member of the group pursuant to a reinsurance contract issued in the name of the group;

2581 (D) in addition to complying with the other provisions of this Subsection (6)(d)(iv),  
2582 maintain a joint trusteed surplus of which \$100,000,000 is held jointly for the benefit of the one  
2583 or more United States domiciled ceding insurers of a member of the group as additional  
2584 security for these liabilities; and

2585 (E) within 90 days after the day on which the group's financial statements are due to be  
2586 filed with the group's domiciliary regulator, make available to the commissioner:

2587 (I) an annual certification of each underwriter member's solvency by the member's  
2588 domiciliary regulator; and

2589 (II) a financial statement of each underwriter member of the group prepared by an  
2590 independent public accountant.

2591 ~~[(7) If reinsurance is ceded to an assuming insurer not meeting the requirements of~~  
2592 ~~Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the~~  
2593 ~~insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law~~  
2594 ~~or regulation of that jurisdiction.]~~

2595 [(8)] (7) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an  
2596 assuming insurer that secures its obligations in accordance with this Subsection [(8)] (7):

2597 (a) The insurer shall be certified by the commissioner as a reinsurer in this state.

2598 (b) To be eligible for certification, the assuming insurer shall:

- 2599 (i) be domiciled and licensed to transact insurance or reinsurance in a qualified  
2600 jurisdiction, as determined by the commissioner pursuant to Subsection [~~(8)~~] (7)(d);
- 2601 (ii) maintain minimum capital and surplus, or its equivalent, in an amount to be  
2602 determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter  
2603 3, Utah Administrative Rulemaking Act;
- 2604 (iii) maintain financial strength ratings from two or more rating agencies considered  
2605 acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter  
2606 3, Utah Administrative Rulemaking Act; and
- 2607 (iv) agree to:
- 2608 (A) submit to the jurisdiction of this state;
- 2609 (B) appoint the commissioner as its agent for service of process in this state;
- 2610 (C) provide security for 100% of the assuming insurer's liabilities attributable to  
2611 reinsurance ceded by United States ceding insurers if it resists enforcement of a final United  
2612 States judgment;
- 2613 (D) agree to meet applicable information filing requirements as determined by the  
2614 commissioner including an application for certification, a renewal and on an ongoing basis; and
- 2615 (E) any other requirements for certification considered relevant by the commissioner.
- 2616 (c) An association, including incorporated and individual unincorporated underwriters,  
2617 may be a certified reinsurer. To be eligible for certification, in addition to satisfying  
2618 requirements of Subsections [~~(8)~~] (7)(a) and (b), the association:
- 2619 (i) shall satisfy its minimum capital and surplus requirements through the capital and  
2620 surplus equivalents, net of liabilities, of the association and its members, which shall include a  
2621 joint central fund that may be applied to any unsatisfied obligation of the association or any of  
2622 its members in an amount determined by the commissioner to provide adequate protection;
- 2623 (ii) may not have incorporated members of the association engaged in any business  
2624 other than underwriting as a member of the association;
- 2625 (iii) shall be subject to the same level of regulation and solvency control of the  
2626 incorporated members of the association by the association's domiciliary regulator as are the  
2627 unincorporated members; and
- 2628 (iv) within 90 days after its financial statements are due to be filed with the  
2629 association's domiciliary regulator provide:

2630 (A) to the commissioner an annual certification by the association's domiciliary  
2631 regulator of the solvency of each underwriter member; or

2632 (B) if a certification is unavailable, financial statements prepared by independent  
2633 public accountants, of each underwriter member of the association.

2634 (d) The commissioner shall create and publish a list of qualified jurisdictions under  
2635 which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be  
2636 considered for certification by the commissioner as a certified reinsurer.

2637 (i) To determine whether the domiciliary jurisdiction of a non-United States assuming  
2638 insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:

2639 (A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory  
2640 system of the jurisdiction, both initially and on an ongoing basis;

2641 (B) shall consider the rights, the benefits, and the extent of reciprocal recognition  
2642 afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the  
2643 United States;

2644 (C) shall require the qualified jurisdiction to share information and cooperate with the  
2645 commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and

2646 (D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has  
2647 determined that the jurisdiction does not adequately and promptly enforce final United States  
2648 judgments and arbitration awards.

2649 (ii) The commissioner may consider additional factors in determining a qualified  
2650 jurisdiction.

2651 (iii) A list of qualified jurisdictions shall be published through the National  
2652 Association of Insurance Commissioners' Committee Process and the commissioner shall:

2653 (A) consider this list in determining qualified jurisdictions; and

2654 (B) if the commissioner approves a jurisdiction as qualified that does not appear on the  
2655 National Association of Insurance Commissioner's list of qualified jurisdictions, provide  
2656 thoroughly documented justification in accordance with criteria to be developed by rule made  
2657 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2658 (iv) United States jurisdictions that meet the requirement for accreditation under the  
2659 National Association of Insurance Commissioners' financial standards and accreditation  
2660 program shall be recognized as qualified jurisdictions.

2661 (v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction,  
2662 the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.

2663 (e) The commissioner shall:

2664 (i) assign a rating to each certified reinsurer, giving due consideration to the financial  
2665 strength ratings that have been assigned by rating agencies considered acceptable to the  
2666 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative  
2667 Rulemaking Act; and

2668 (ii) publish a list of all certified reinsurers and their ratings.

2669 (f) A certified reinsurer shall secure obligations assumed from United States ceding  
2670 insurers under this Subsection [~~(8)~~] (7) at a level consistent with its rating, as specified in rules  
2671 made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative  
2672 Rulemaking Act.

2673 (i) For a domestic ceding insurer to qualify for full financial statement credit for  
2674 reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a  
2675 form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a  
2676 multibeneficiary trust in accordance with Subsections (5), (6), and [~~(7)~~] (9), except as  
2677 otherwise provided in this Subsection [~~(8)~~] (7).

2678 (ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to  
2679 Subsections (5), (6), and [~~(7)~~] (9), and chooses to secure its obligations incurred as a certified  
2680 reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate  
2681 trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a  
2682 certified reinsurer with reduced security as permitted by this Subsection [~~(8)~~] (7) or comparable  
2683 laws of other United States jurisdictions and for its obligations subject to Subsections (5), (6),  
2684 and [~~(7)~~] (9).

2685 (iii) It shall be a condition to the grant of certification under this Subsection [~~(8)~~] (7)  
2686 that the certified reinsurer shall have bound itself:

2687 (A) by the language of the trust and agreement with the commissioner with principal  
2688 regulatory oversight of the trust account; and

2689 (B) upon termination of the trust account, to fund, out of the remaining surplus of the  
2690 trust, any deficiency of any other trust account.

2691 (iv) The minimum trusteed surplus requirements provided in Subsections (5), (6), and

2692 [(7)] (9) are not applicable with respect to a multibeneficiary trust maintained by a certified  
2693 reinsurer for the purpose of securing obligations incurred under this Subsection [(8)] (7),  
2694 except that the trust shall maintain a minimum trusteed surplus of \$10,000,000.

2695 (v) With respect to obligations incurred by a certified reinsurer under this Subsection  
2696 [(8)] (7), if the security is insufficient, the commissioner:

2697 (A) shall reduce the allowable credit by an amount proportionate to the deficiency; and

2698 (B) may impose further reductions in allowable credit upon finding that there is a  
2699 material risk that the certified reinsurer's obligations will not be paid in full when due.

2700 (vi) For purposes of this Subsection [(8)] (7), a certified reinsurer whose certification  
2701 has been terminated for any reason shall be treated as a certified reinsurer required to secure  
2702 100% of its obligations.

2703 (A) As used in this Subsection [(8)] (7), the term "terminated" refers to revocation,  
2704 suspension, voluntary surrender, and inactive status.

2705 (B) If the commissioner continues to assign a higher rating as permitted by other  
2706 provisions of this section, the requirement under this Subsection [(8)] (7)(f)(vi) does not apply  
2707 to a certified reinsurer in inactive status or to a reinsurer whose certification has been  
2708 suspended.

2709 (g) If an applicant for certification has been certified as a reinsurer in a National  
2710 Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:

2711 (i) defer to that jurisdiction's certification;

2712 (ii) defer to the rating assigned by that jurisdiction; and

2713 (iii) consider such reinsurer to be a certified reinsurer in this state.

2714 (h) (i) A certified reinsurer that ceases to assume new business in this state may request  
2715 to maintain its certification in inactive status in order to continue to qualify for a reduction in  
2716 security for its in-force business.

2717 (ii) An inactive certified reinsurer shall continue to comply with all applicable  
2718 requirements of this Subsection [(8)] (7).

2719 (iii) The commissioner shall assign a rating to a reinsurer that qualifies under this  
2720 Subsection [(8)] (7)(h), that takes into account, if relevant, the reasons why the reinsurer is not  
2721 assuming new business.

2722 (8) (a) As used in this Subsection (8):



2723 (i) "Covered agreement" means an agreement entered into pursuant to Dodd-Frank  
2724 Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that is  
2725 currently in effect or in a period of provisional application and addresses the elimination, under  
2726 specified conditions, of collateral requirements as a condition for entering into any reinsurance  
2727 agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to  
2728 recognize credit for reinsurance.

2729 (ii) "Reciprocal jurisdiction" means a jurisdiction that is:

2730 (A) a non-United States jurisdiction that is subject to an in-force covered agreement  
2731 with the United States, each within its legal authority, or, in the case of a covered agreement  
2732 between the United States and European Union, is a member state of the European Union;

2733 (B) a United States jurisdiction that meets the requirements for accreditation under the  
2734 National Association of Insurance Commissioners' financial standards and accreditation  
2735 program; or

2736 (C) a qualified jurisdiction, as determined by the commissioner in accordance with  
2737 Subsection (7)(d), that is not otherwise described in this Subsection (8)(a)(ii) and meets certain  
2738 additional requirements, consistent with the terms and conditions of in-force covered  
2739 agreements, as specified by the commissioner in rule made in accordance with Title 63G,  
2740 Chapter 3, Utah Administrative Rulemaking Act.

2741 (b) (i) Credit shall be allowed when the reinsurance is ceded to an assuming insurer  
2742 meeting each of the conditions set forth in this Subsection (8)(b).

2743 (ii) The assuming insurer must have its head office or be domiciled in, as applicable,  
2744 and be licensed in a reciprocal jurisdiction.

2745 (iii) (A) The assuming insurer must have and maintain, on an ongoing basis, minimum  
2746 capital and surplus, or its equivalent, calculated according to the methodology of its  
2747 domiciliary jurisdiction, in an amount to be set forth in regulation.

2748 (B) If the assuming insurer is an association, including incorporated and individual  
2749 unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital  
2750 and surplus equivalents (net of liabilities), calculated according to the methodology applicable  
2751 in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth  
2752 in regulation.

2753 (iv) (A) The assuming insurer must have and maintain, on an ongoing basis, a

2754 minimum solvency or capital ration, as applicable, which will be set forth in regulation.

2755 (B) If the assuming insurer is an association, including incorporated and individual  
2756 unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum  
2757 solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head  
2758 office or is domiciled, as applicable, and is also licensed.

2759 (v) The assuming insurer must agree and provide adequate assurance to the  
2760 commissioner, in a form specified by the commissioner by rule made in accordance with Title  
2761 63G, Chapter 3, Utah Administrative Rulemaking Act, as follows:

2762 (A) the assuming insurer must provide prompt written notice and explanation to the  
2763 commissioner if it falls below the minimum requirements set forth in Subsections (8)(c) or (d),  
2764 or if any regulatory action is taken against it for serious noncompliance with applicable law;

2765 (B) the assuming insurer must consent in writing to the jurisdiction of the courts of this  
2766 state and to the appointment of the commissioner as agent for service of process, however the  
2767 commissioner may require that consent for service of process be provided to the commissioner  
2768 and included in each reinsurance agreement and nothing in this provision shall limit, or in any  
2769 way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute  
2770 resolution mechanisms, except to the extent such agreements are unenforceable under  
2771 applicable insolvency or delinquency laws;

2772 (C) the assuming insurer must consent in writing to pay all final judgments, wherever  
2773 enforcement is sought, obtained by a ceding insurer or its legal successor, that have been  
2774 declared enforceable in the jurisdiction where the judgment was obtained;

2775 (D) each reinsurance agreement must include a provision requiring the assuming  
2776 insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities  
2777 attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists  
2778 enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it  
2779 was obtained or a properly enforceable arbitration award, whether obtained by the ceding  
2780 insurer or by its legal successor on behalf of its resolution estate; and

2781 (E) the assuming insurer must confirm that it is not presently participating in any  
2782 solvent scheme of arrangement which involved this state's ceding insurers, and agree to notify  
2783 the ceding insurer and the commissioner and to provide security:

2784 (I) in an amount equal to 100% of the assuming insurer's liabilities to the ceding

2785 insurer, should the assuming insurer enter into such a solvent scheme of arrangement; and  
2786 (II) in a form consistent with the provisions of Subsections (7) and (10) and as  
2787 specified by the commissioner in regulation.

2788 (vi) The assuming insurer or its legal successor must provide, if requested by the  
2789 commissioner, on behalf of itself and any legal predecessors, certain documentation to the  
2790 commissioner, as specified by the commissioner by rule made in accordance with Title 63G,  
2791 Chapter 3, Utah Administrative Rulemaking Act.

2792 (vii) The assuming insurer must maintain a practice of prompt payment of claims under  
2793 reinsurance agreements, pursuant to criteria set forth in rule made in accordance with Title  
2794 63G, Chapter 3, Utah Administrative Rulemaking Act.

2795 (viii) The assuming insurer's supervisory authority must confirm to the commissioner  
2796 on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily  
2797 reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements  
2798 set forth in Subsections (8)(c) and (d).

2799 (ix) Nothing in this provision precludes an assuming insurer from providing the  
2800 commissioner with information on a voluntary basis.

2801 (c) (i) The commissioner shall timely create and publish a list of reciprocal  
2802 jurisdictions.

2803 (ii) (A) A list of reciprocal jurisdictions is published through the National Association  
2804 of Insurance Commissioners' Committee Process.

2805 (B) The commissioner's list of reciprocal jurisdictions shall include any reciprocal  
2806 jurisdiction as defined in this Subsection (8), and shall consider any other reciprocal  
2807 jurisdictions in accordance with the criteria developed under rule made in accordance with  
2808 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2809 (iii) (A) The commissioner may remove a jurisdiction from the list of reciprocal  
2810 jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a  
2811 reciprocal jurisdiction, in accordance with a process set forth in rule made in accordance with  
2812 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the commissioner shall  
2813 not remove from the list a reciprocal jurisdiction.

2814 (B) Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance  
2815 ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall

2816 be allowed, if otherwise allowed under this chapter.

2817 (d) (i) The commissioner shall timely create and publish a list of assuming insurers that  
2818 have satisfied the conditions set forth in this subsection and to which cessions shall be granted  
2819 credit in accordance with this Subsection (8).

2820 (ii) The commissioner may add an assuming insurer to such list if a National  
2821 Association of Insurance Commissioners accredited jurisdiction has added such assuming  
2822 insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer  
2823 submits the information to the commissioner as required under this Subsection (8) and  
2824 complies with any additional requirements that the commissioner may impose by rule made in  
2825 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except to the  
2826 extent that they conflict with an applicable covered agreement.

2827 (e) (i) If the commissioner determines that an assuming insurer no longer meets one or  
2828 more of the requirements under this Subsection (8), the commissioner may revoke or suspend  
2829 the eligibility of the assuming insurer for recognition under this Subsection (8) in accordance  
2830 with procedures established in rule made in accordance with Title 63G, Chapter 3, Utah  
2831 Administrative Rulemaking Act.

2832 (ii) (A) While an assuming insurer's eligibility is suspended, no reinsurance agreement  
2833 issued, amended, or renewed after the effective date of the suspension qualifies for credit  
2834 except to the extent that the assuming insurer's obligations under the contract are secured in  
2835 accordance with Subsection (10).

2836 (B) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be  
2837 granted after the effective date of the revocation with respect to any reinsurance agreements  
2838 entered into by the assuming insurer, including reinsurance agreements entered into prior to the  
2839 date of revocation, except to the extent that the assuming insurer's obligations under the  
2840 contract are secured in a form acceptable to the commissioner and consistent with the  
2841 provisions of Subsection (10).

2842 (f) If subject to a legal process of rehabilitation, liquidation, or conservation, as  
2843 applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by  
2844 the court in which the proceedings are pending, may obtain an order requiring that the  
2845 assuming insurer post security for all outstanding ceded liabilities.

2846 (g) Nothing in this Subsection (8) limits or in any way alters the capacity of parties to a

2847 reinsurance agreement to agree on requirements for security or other terms in that reinsurance  
2848 agreement, except as expressly prohibited by this chapter or other applicable law or regulation.

2849 (h) (i) Credit may be taken under this Subsection (8) only for reinsurance agreements  
2850 entered into, amended, or renewed on or after the effective date of the statute adding this  
2851 Subsection (8), and only with respect to losses incurred and reserves reported on or after the  
2852 later of:

2853 (A) the date on which the assuming insurer has met all eligibility requirements  
2854 pursuant to Subsection (8)(b); and

2855 (B) the effective date of the new reinsurance agreement, amendment or renewal.

2856 (ii) This Subsection (8) does not alter or impair a ceding insurer's right to take credit  
2857 for reinsurance, to the extent that credit is not available under this Subsection (8), as long as the  
2858 reinsurance qualifies for credit under any other applicable provision of this chapter.

2859 (iii) Nothing in this Subsection (8) authorizes an assuming insurer to withdraw or  
2860 reduce the security provided under any reinsurance agreement except as permitted by the terms  
2861 of the agreement.

2862 (iv) Nothing in this Subsection (8) limits, or in any way alters, the capacity of parties to  
2863 any reinsurance agreement to renegotiate the agreement.

2864 (9) If reinsurance is ceded to an assuming insurer not meeting the requirements of  
2865 Subsection (3), (4), (5), (6), (7), or (8), a domestic ceding insurer is allowed credit only as to  
2866 the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable  
2867 law or regulation of that jurisdiction.

2868 (10) (a) An asset or a reduction from liability for the reinsurance ceded by a domestic  
2869 insurer to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7),  
2870 or (8) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

2871 (b) The commissioner may adopt by rule made in accordance with Title 63G, Chapter  
2872 3, Utah Administrative Rulemaking Act, specific additional requirements relating to or setting  
2873 forth:

2874 (i) the valuation of assets or reserve credits;

2875 (ii) the amount and forms of security supporting reinsurance arrangements; and

2876 (iii) the circumstances pursuant to which credit will be reduced or eliminated.

2877 (c) (i) The reduction shall be in the amount of funds held by or on behalf of the ceding

2878 insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with  
2879 the assuming insurer as security for the payment of obligations thereunder, if the security is:

2880 (A) held in the United States subject to withdrawal solely by, and under the exclusive  
2881 control of, the ceding insurer; or

2882 (B) in the case of a trust, held in a qualified United States financial institution.

2883 (ii) The security described in this Subsection (10)(c) may be in the form of:

2884 (A) cash;

2885 (B) securities listed by the Securities Valuation Office of the National Association of  
2886 Insurance Commissioners, including those deemed exempt from filing as defined by the  
2887 Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted  
2888 assets;

2889 (C) clean, irrevocable, unconditional letters of credit, issued or confirmed by a  
2890 qualified United States financial institution effective no later than December 31 of the year for  
2891 which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or  
2892 before the filing date of its annual statement;

2893 (D) letters of credit meeting applicable standards of issuer acceptability as of the dates  
2894 of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's  
2895 subsequent failure to meet applicable standards of issuer acceptability, continue to be  
2896 acceptable as security until their expiration, extension, renewal, modification or amendment,  
2897 whichever first occurs; or

2898 (E) any other form of security acceptable to the commissioner.

2899 ~~[(9)]~~ (11) Reinsurance credit may not be allowed a domestic ceding insurer unless the  
2900 assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

2901 (a) (i) being an admitted insurer; and

2902 (ii) submitting to jurisdiction under Section 31A-2-309;

2903 (b) having irrevocably appointed the commissioner as the domestic ceding insurer's  
2904 agent for service of process in an action arising out of or in connection with the reinsurance,  
2905 which appointment is made under Section 31A-2-309; or

2906 (c) agreeing in the reinsurance contract:

2907 (i) that if the assuming insurer fails to perform its obligations under the terms of the  
2908 reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

2909 (A) submit to the jurisdiction of a court of competent jurisdiction in a state of the  
2910 United States;

2911 (B) comply with all requirements necessary to give the court jurisdiction; and

2912 (C) abide by the final decision of the court or of an appellate court in the event of an  
2913 appeal; and

2914 (ii) to designate the commissioner or a specific attorney licensed to practice law in this  
2915 state as its attorney upon whom may be served lawful process in an action, suit, or proceeding  
2916 instituted by or on behalf of the ceding company.

2917 [~~(10)~~] (12) Submitting to the jurisdiction of Utah courts under Subsection [~~(9)~~] (11)  
2918 does not override a duty or right of a party under the reinsurance contract, including a  
2919 requirement that the parties arbitrate their disputes.

2920 [~~(11)~~] (13) If an assuming insurer does not meet the requirements of Subsection (3),  
2921 (4), [~~or~~] (5), or (8), the credit permitted by Subsection (6) or [~~(8)~~] (7) may not be allowed  
2922 unless the assuming insurer agrees in the trust instrument to the following conditions:

2923 (a) (i) Notwithstanding any other provision in the trust instrument, if an event  
2924 described in Subsection [~~(11)~~] (13)(a)(ii) occurs the trustee shall comply with:

2925 (A) an order of the commissioner with regulatory oversight over the trust; or

2926 (B) an order of a court of competent jurisdiction directing the trustee to transfer to the  
2927 commissioner with regulatory oversight all of the assets of the trust fund.

2928 (ii) This Subsection [~~(11)~~] (13)(a) applies if:

2929 (A) the trust fund is inadequate because the trust contains an amount less than the  
2930 amount required by Subsection (6)(d); or

2931 (B) the grantor of the trust is:

2932 (I) declared insolvent; or

2933 (II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the  
2934 laws of its state or country of domicile.

2935 (b) The assets of a trust fund described in Subsection [~~(11)~~] (13)(a) shall be distributed  
2936 by and a claim shall be filed with and valued by the commissioner with regulatory oversight in  
2937 accordance with the laws of the state in which the trust is domiciled that are applicable to the  
2938 liquidation of a domestic insurance company.

2939 (c) If the commissioner with regulatory oversight determines that the assets of the trust

2940 fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United  
2941 States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be  
2942 returned by the commissioner with regulatory oversight to the trustee for distribution in  
2943 accordance with the trust instrument.

2944 (d) A grantor shall waive any right otherwise available to it under United States law  
2945 that is inconsistent with this Subsection [~~(11)~~] (13).

2946 [~~(12)~~] (14) If an accredited or certified reinsurer ceases to meet the requirements for  
2947 accreditation or certification, the commissioner may suspend or revoke the reinsurer's  
2948 accreditation or certification.

2949 (a) The commissioner shall give the reinsurer notice and opportunity for hearing.

2950 (b) The suspension or revocation may not take effect until after the commissioner's  
2951 order after a hearing, unless:

2952 (i) the reinsurer waives its right to hearing;

2953 (ii) the commissioner's order is based on:

2954 (A) regulatory action by the reinsurer's domiciliary jurisdiction; or

2955 (B) the voluntary surrender or termination of the reinsurer's eligibility to transact  
2956 insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state  
2957 under Subsection [~~(8)~~] (7)(g); or

2958 (iii) the commissioner's finding that an emergency requires immediate action and a  
2959 court of competent jurisdiction has not stayed the commissioner's action.

2960 (c) While a reinsurer's accreditation or certification is suspended, no reinsurance  
2961 contract issued or renewed after the effective date of the suspension qualifies for credit except  
2962 to the extent that the reinsurer's obligations under the contract are secured in accordance with  
2963 Section 31A-17-404.1.

2964 (d) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance  
2965 may be granted after the effective date of the revocation except to the extent that the reinsurer's  
2966 obligations under the contract are secured in accordance with Subsection [~~(8)~~] (7)(f) or Section  
2967 31A-17-404.1.

2968 [~~(13)~~] (15) (a) A ceding insurer shall take steps to manage its reinsurance recoverables  
2969 proportionate to its own book of business.

2970 (b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after



2971 reinsurance recoverables from any single assuming insurer, or group of affiliated assuming  
2972 insurers:

2973 (A) exceeds 50% of the domestic ceding insurer's last reported surplus to  
2974 policyholders; or

2975 (B) after it is determined that reinsurance recoverables from any single assuming  
2976 insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding  
2977 insurer's last reported surplus to policyholders.

2978 (ii) The notification required by Subsection [~~(13)~~] (15)(b)(i) shall demonstrate that the  
2979 exposure is safely managed by the domestic ceding insurer.

2980 (c) A ceding insurer shall take steps to diversify its reinsurance program.

2981 (d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after  
2982 ceding or being likely to cede more than 20% of the ceding insurer's gross written premium in  
2983 the prior calendar year to any:

2984 (A) single assuming insurer; or

2985 (B) group of affiliated assuming insurers.

2986 (ii) The notification shall demonstrate that the exposure is safely managed by the  
2987 domestic ceding insurer.

2988 Section 17. Section **31A-17-404.3** is amended to read:

2989 **31A-17-404.3. Rules.**

2990 (1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and  
2991 this chapter, the commissioner may make rules prescribing:

2992 (a) the form of a letter of credit required under this chapter;

2993 (b) the requirements for a trust or trust instrument required by this chapter;

2994 (c) the procedures for licensing and accrediting;

2995 (d) minimum capital and surplus requirements;

2996 (e) additional requirements relating to calculation of credit allowed a domestic ceding  
2997 insurer against reserves for reinsurance under Section [31A-17-404](#); and

2998 (f) additional requirements relating to calculation of asset reduction from liability for  
2999 reinsurance ceded by a domestic insurer to other ceding insurers under Section [31A-17-404.1](#).

3000 (2) A rule made pursuant to Subsection (1)(e) or (f) may apply to reinsurance relating  
3001 to:

3002 (a) a life insurance policy with guaranteed nonlevel gross premiums or guaranteed  
3003 nonlevel benefits;

3004 (b) a universal life insurance policy with provisions resulting in the ability of a  
3005 policyholder to keep a policy in force over a secondary guarantee period;

3006 (c) a variable annuity with guaranteed death or living benefits;

3007 (d) a long-term care insurance policy; or

3008 (e) such other life and health insurance or annuity product as to which the National  
3009 Association of Insurance Commissioners adopts model regulatory requirements with respect  
3010 for credit for reinsurance.

3011 (3) A rule adopted pursuant to Subsection (1)(e) or (f) may apply to a treaty containing:

3012 (a) a policy issued on or after January 1, 2015; and

3013 (b) a policy issued before January 1, 2015, if risk pertaining to the policy is ceded in  
3014 connection with the treaty, either in whole or in part, on or after January 1, 2015.

3015 (4) A rule adopted pursuant to Subsection (1)(e) or (f) may require the ceding insurer,  
3016 in calculating the amounts or forms of security required to be held under rules made under this  
3017 section, to use the Valuation Manual adopted by the National Association of Insurance  
3018 Commissioners under Section 11B(1) of the National Association of Insurance Commissioners  
3019 Standard Valuation Law, including all amendments adopted by the National Association of  
3020 Insurance Commissioners and in effect on the date as of which the calculation is made, to the  
3021 extent applicable.

3022 (5) A rule adopted pursuant to Subsection (1)(e) or (f) may not apply to cessions to an  
3023 assuming insurer that:

3024 (a) meets the conditions established in Subsection [31A-17-404\(8\)](#);

3025 ~~[(a)] (b) is certified in this state [or, if this state has not adopted provisions~~  
3026 ~~substantially equivalent to Section 2E of the Credit for Reinsurance Model Law, certified in a~~  
3027 ~~minimum of five other states]; or~~

3028 ~~[(b)] (c) maintains at least \$250,000,000 in capital and surplus when determined in~~  
3029 ~~accordance with the National Association of Insurance Commissioners Accounting Practices~~  
3030 ~~and Procedures Manual, including all amendments thereto adopted by the National Association~~  
3031 ~~of Insurance Commissioners, excluding the impact of any permitted or prescribed practices and~~  
3032 ~~is:~~

3033 (i) licensed in at least 26 states; or  
3034 (ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35  
3035 states.

3036 (6) The authority to adopt rules pursuant to Subsection (1)(e) or (f) does not otherwise  
3037 limit the commissioner's general authority to make rules pursuant to Subsection (1).

3038 Section 18. Section **31A-17-601** is amended to read:

3039 **31A-17-601. Definitions.**

3040 As used in this part:

3041 (1) "Adjusted RBC report" means an RBC report that has been adjusted by the  
3042 commissioner in accordance with Subsection [31A-17-602\(5\)](#).

3043 (2) "Corrective order" means an order issued by the commissioner specifying  
3044 corrective action that the commissioner determines is required.

3045 (3) "Health organization" means:

3046 (a) an entity that is authorized under Chapter 7, Nonprofit Health Service Insurance  
3047 Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

3048 (b) that is:

3049 (i) a health maintenance organization;

3050 (ii) a limited health service organization;

3051 (iii) a dental or vision plan;

3052 (iv) a hospital, medical, and dental indemnity or service corporation; or

3053 (v) other managed care organization.

3054 (4) "Life or accident and health insurer" means:

3055 (a) an insurance company licensed to write life insurance, disability insurance, or both;

3056 or

3057 (b) a licensed property casualty insurer writing only disability insurance.

3058 (5) "Property and casualty insurer" means any insurance company licensed to write  
3059 lines of insurance other than life but does not include a monoline mortgage guaranty insurer,  
3060 financial guaranty insurer, or title insurer.

3061 (6) "RBC" means risk-based capital.

3062 (7) "RBC instructions" means the RBC report including the National Association of  
3063 Insurance Commissioner's risk-based capital instructions [~~adopted by the department by rule~~]

3064 that govern the year for which an RBC report is prepared.

3065 (8) "RBC level" means an insurer's or health organization's authorized control level  
3066 RBC, company action level RBC, mandatory control level RBC, or regulatory action level  
3067 RBC.

3068 (a) "Authorized control level RBC" means the number determined under the risk-based  
3069 capital formula in accordance with the RBC instructions;

3070 (b) "Company action level RBC" means the product of 2.0 and its authorized control  
3071 level RBC;

3072 (c) "Mandatory control level RBC" means the product of .70 and the authorized control  
3073 level RBC; and

3074 (d) "Regulatory action level RBC" means the product of 1.5 and its authorized control  
3075 level RBC.

3076 (9) (a) "RBC plan" means a comprehensive financial plan containing the elements  
3077 specified in Subsection [31A-17-603\(2\)](#).

3078 (b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:

3079 (i) the commissioner rejects the RBC plan; and

3080 (ii) the plan is revised by the insurer or health organization, with or without the  
3081 commissioner's recommendation.

3082 (10) "RBC report" means the report required in Section [31A-17-602](#).

3083 Section 19. Section **31A-19a-404** is amended to read:

3084 **31A-19a-404. Designated rate service organization.**

3085 (1) For purposes of workers' compensation insurance, the commissioner shall designate  
3086 one rate service organization to:

3087 (a) develop and administer the uniform statistical plan, uniform classification plan, and  
3088 uniform experience rating plan filed with and approved by the commissioner;

3089 (b) assist the commissioner in gathering, compiling, and reporting relevant statistical  
3090 information on an aggregate basis;

3091 (c) develop and file manual rules, subject to the approval of the commissioner, that are  
3092 reasonably related to the recording and reporting of data pursuant to the uniform statistical  
3093 plan, uniform experience rating plan, and the uniform classification plan; and

3094 (d) develop and file the [~~prospective~~] advisory loss costs pursuant to Section

3095 31A-19a-406.

3096 (2) The uniform experience rating plan shall:

3097 (a) contain reasonable eligibility standards;

3098 (b) provide adequate incentives for loss prevention; and

3099 (c) provide for sufficient premium differentials so as to encourage safety.

3100 (3) Each workers' compensation insurer, directly or through its selected rate service  
3101 organization, shall:

3102 (a) record and report its workers' compensation experience to the designated rate  
3103 service organization as set forth in the uniform statistical plan approved by the commissioner;  
3104 and

3105 (b) adhere to a uniform classification plan and uniform experience rating plan filed  
3106 with the commissioner by the rate service organization designated by the commissioner[; and].

3107 [~~(c) adhere to the prospective loss costs filed by the designated rate service~~  
3108 ~~organization.~~]

3109 (4) The commissioner may adopt rules for:

3110 (a) the development and administration by the designated rate service organization of  
3111 the:

3112 (i) uniform statistical plan;

3113 (ii) uniform experience rating plan; and

3114 (iii) uniform classification plan;

3115 (b) the recording and reporting of statistical data and experience rating data by the  
3116 various insurers writing workers' compensation insurance;

3117 (c) the selection, retention, and termination of the designated rate service organization;  
3118 and

3119 (d) providing for the equitable sharing and recovery of the expense of the designated  
3120 rate service organization to develop, maintain, and provide the plans, services, and filings that  
3121 are used by the various insurers writing workers' compensation insurance.

3122 (5) (a) Notwithstanding Subsection (3), an insurer may develop directly or through its  
3123 selected rate service organization subclassifications of the uniform classification system upon  
3124 which a rate may be made.

3125 (b) A subclassification shall be filed with the commissioner 30 days before its use.

3126 (c) The commissioner shall disapprove subclassifications if the insurer fails to  
3127 demonstrate that the data produced by the subclassifications can be reported consistently with  
3128 the uniform statistical plan and uniform classification plan.

3129 (6) Notwithstanding Subsection (3), an insurer may, directly or through its selected rate  
3130 service organization, develop its own experience modifications based on the uniform statistical  
3131 plan, uniform classification plan, and uniform rating plan filed by the rate service organization  
3132 designated by the commissioner under Subsection (1).

3133 Section 20. Section **31A-19a-405** is amended to read:

3134 **31A-19a-405. Filing of rates and other rating information.**

3135 (1) (a) All workers' compensation rates, supplementary rate information, and supporting  
3136 information shall be filed at least 30 days before the effective date of the rate or information.

3137 (b) Notwithstanding Subsection (1)(a), on application by the filer, the commissioner  
3138 may authorize an earlier effective date.

3139 (2) The loss and loss adjustment expense factors included in the rates filed under  
3140 Subsection (1) shall be:

3141 (a) the ~~[prospective]~~ advisory loss costs filed by the designated rate service  
3142 organization under Section 31A-19a-406~~[-];~~ or

3143 (b) a percent modification of the advisory loss costs filed by the designated rate service  
3144 organization under Section 31A-19a-406.

3145 (3) A modification filed under Subsection (2)(b) shall be accompanied by adequate  
3146 support as required by Part 2, General Rate Regulation.

3147 Section 21. Section **31A-19a-406** is amended to read:

3148 **31A-19a-406. Filing requirements for designated rate service organization.**

3149 (1) The rate service organization designated under Section 31A-19a-404 shall file with  
3150 the commissioner the following items proposed for use in this state at least 30 calendar days  
3151 before the ~~[date they]~~ day on which the items are distributed to members, subscribers, or  
3152 others:

3153 (a) each ~~[prospective]~~ advisory loss cost with its supporting information;

3154 (b) the uniform classification plan and rating manual;

3155 (c) the uniform experience rating plan manual;

3156 (d) the uniform statistical plan manual; and

3157 (e) each change, amendment, or modification of any of the items listed in Subsections  
3158 (1)(a) through (d).

3159 (2) (a) If the commissioner believes that [~~prospective~~] advisory loss costs filed violate  
3160 the excessive, inadequate, or unfair discriminatory standard in Section 31A-19a-201 or any  
3161 other applicable requirement of this part, the commissioner may require that the rate service  
3162 organization file additional supporting information.

3163 (b) If, after reviewing the supporting information, the commissioner determines that  
3164 the [~~prospective~~] advisory loss costs violate these requirements, the commissioner may:

- 3165 (i) require that adjustments to the [~~prospective~~] advisory loss costs be made; or
- 3166 (ii) call a hearing for any purpose regarding the filing.

3167 Section 22. Section 31A-21-201 is amended to read:

3168 **31A-21-201. Filing of forms.**

3169 (1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may  
3170 not be used, sold, or offered for sale until the form is filed with the commissioner.

3171 (b) A form is considered filed with the commissioner when the commissioner receives:

- 3172 (i) the form;
- 3173 (ii) the applicable filing fee as prescribed under Section 31A-3-103; and
- 3174 (iii) the applicable transmittal forms as required by the commissioner.

3175 (2) In filing a form for use in this state the insurer is responsible for assuring that the  
3176 form is in compliance with this title and rules adopted by the commissioner.

3177 (3) (a) The commissioner may prohibit the use of a form at any time upon a finding  
3178 that:

- 3179 (i) the form:
  - 3180 (A) is inequitable;
  - 3181 (B) is unfairly discriminatory;
  - 3182 (C) is misleading;
  - 3183 (D) is deceptive;
  - 3184 (E) is obscure;
  - 3185 (F) is unfair;
  - 3186 (G) encourages misrepresentation; or
  - 3187 (H) is not in the public interest;

3188 (ii) the form provides benefits or contains another provision that endangers the solidity  
3189 of the insurer;

3190 (iii) except for a life or accident and health insurance policy form, the form is an  
3191 insurance policy or application for an insurance policy, that fails to conspicuously, as defined  
3192 by rule, provide:

3193 (A) the exact name of the insurer; and

3194 (B) the state of domicile of the insurer filing the insurance policy or application for the  
3195 insurance policy;

3196 ~~[(iii)]~~ (iv) except an application required by Section 31A-22-635, [the form is an  
3197 insurance policy or application for an insurance policy] the form is a life or accident and health  
3198 insurance policy form that fails to conspicuously, as defined by rule, provide:

3199 (A) the exact name of the insurer;

3200 (B) the state of domicile of the insurer filing the insurance policy or application for the  
3201 insurance policy; and

3202 (C) for a life insurance ~~[and annuity insurance]~~ policy only, the address of the  
3203 administrative office of the insurer filing the ~~[insurance policy or application for the insurance~~  
3204 ~~policy] form;~~

3205 ~~[(iv)]~~ (v) the form violates a statute or a rule adopted by the commissioner; or

3206 ~~[(v)]~~ (vi) the form is otherwise contrary to law.

3207 (b) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the  
3208 commissioner may order that, on or before a date not less than 15 days after the order, the use  
3209 of the form be discontinued.

3210 (ii) Once use of a form is prohibited, the form may not be used until appropriate  
3211 changes are filed with and reviewed by the commissioner.

3212 (iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the  
3213 commissioner may require the insurer to disclose contract deficiencies to the existing  
3214 policyholders.

3215 (c) If the commissioner prohibits use of a form under this Subsection (3), the  
3216 prohibition shall:

3217 (i) be in writing;

3218 (ii) constitute an order; and



3219 (iii) state the reasons for the prohibition.

3220 (4) (a) If, after a hearing, the commissioner determines that it is in the public interest,  
3221 the commissioner may require by rule or order that a form be subject to the commissioner's  
3222 approval before its use.

3223 (b) The rule or order described in Subsection (4)(a) shall prescribe the filing  
3224 procedures for a form if the procedures are different from the procedures stated in this section.

3225 (c) The type of form that under Subsection (4)(a) the commissioner may require  
3226 approval of before use includes:

3227 (i) a form for a particular class of insurance;  
3228 (ii) a form for a specific line of insurance;  
3229 (iii) a specific type of form; or  
3230 (iv) a form for a specific market segment.

3231 (5) (a) An insurer shall maintain a complete and accurate record of the following for  
3232 the time period described in Subsection (5)(b):

3233 (i) a form:  
3234 (A) filed under this section for use; or  
3235 (B) that is in use; and  
3236 (ii) a document filed under this section with a form described in Subsection (5)(a)(i).

3237 (b) The insurer shall maintain a record required under Subsection (5)(a) for the balance  
3238 of the current year, plus five years from:

3239 (i) the last day on which the form is used; or  
3240 (ii) the last day an insurance policy that is issued using the form is in effect.

3241 Section 23. Section **31A-21-301** is amended to read:

3242 **31A-21-301. Clauses required to be in a prominent position.**

3243 (1) The following portions of insurance policies shall appear conspicuously in the  
3244 policy:

3245 (a) as required by [~~Subsection~~] Subsections 31A-21-201(3)(a)(iii) and (iv):

3246 (i) the exact name of the insurer;  
3247 (ii) the state of domicile of the insurer; and  
3248 (iii) for life insurance and annuity policies only, the address of the administrative office  
3249 of the insurer;

- 3250 (b) information that two or more insurers under Subsection (1)(a) undertake only
  - 3251 several liability, as required by Section 31A-21-306;
  - 3252 (c) if a policy is assessable, a statement of that;
  - 3253 (d) a statement that benefits are variable, as required by Section 31A-22-411; however,
  - 3254 the methods of calculation need not be in a prominent position;
  - 3255 (e) the right to return a life or accident and health insurance policy under Sections
  - 3256 31A-22-423 and 31A-22-606; and
  - 3257 (f) the beginning and ending dates of insurance protection.
- 3258 (2) Each clause listed in Subsection (1) shall be displayed conspicuously and separately
- 3259 from any other clause.

3260 Section 24. Section 31A-21-313 is amended to read:

3261 **31A-21-313. Limitation of actions.**

3262 (1) (a) An action on a written policy or contract of first party insurance shall be

3263 commenced within three years after the inception of the loss.

3264 (b) The inception of the loss on a fidelity bond is the date the insurer first denies all or

3265 part of a claim made under the fidelity bond.

3266 (2) Except as provided in Subsection (1) or elsewhere in this title, the law applicable to

3267 limitation of actions in Title 78B, Chapter 2, Statutes of Limitations, applies to actions on

3268 insurance policies.

3269 (3) An insurance policy may not:

3270 (a) limit the time for beginning an action on the policy to a time less than that

3271 authorized by statute;

3272 (b) prescribe in what court an action may be brought on the policy; or

3273 (c) provide that no action may be brought, subject to permissible arbitration provisions

3274 in contracts.

3275 (4) (a) Unless by verified complaint it is alleged that prejudice to the complainant will

3276 arise from a delay in bringing suit against an insurer, which prejudice is other than the delay

3277 itself, no action may be brought against an insurer on an insurance policy to compel payment

3278 under the policy until the earlier of:

3279 ~~(a)~~ (i) 60 days after proof of loss has been furnished as required under the policy;

3280 ~~(b)~~ (ii) waiver by the insurer of proof of loss; or

3281 ~~[(e)]~~ (iii) (A) the insurer's denial of full payment[-]; or  
3282 (B) for an accident and health insurance policy, the insurer's denial of payment.  
3283 (b) Under an accident and health insurance policy, an insurer may not require the  
3284 completion of an appeals process that exceeds the provisions in 29 C.F.R. Sec. 2560.503-1 to  
3285 bring suit under this Subsection (4).

3286 (5) The period of limitation is tolled during the period in which the parties conduct an  
3287 appraisal or arbitration procedure prescribed by the insurance policy, by law, or as agreed to by  
3288 the parties.

3289 Section 25. Section **31A-22-205** is enacted to read:

3290 **31A-22-205. Applicability of Restatement of the Law of Liability Insurance.**

3291 (1) As used in this section, "restatement" means the American Law Institute's  
3292 Restatement of the Law of Liability Insurance.

3293 (2) The restatement is not the law or public policy of this state if the restatement is  
3294 inconsistent or in conflict with or otherwise not addressed by:

3295 (a) the Constitution of the United States;  
3296 (b) the Utah Constitution;  
3297 (c) a state statute;  
3298 (d) state case law; or  
3299 (e) state-adopted common law.

3300 (3) The restatement is not a source of Utah law.

3301 (4) A court may not apply or recognize the restatement as an authoritative reference  
3302 regarding state liability insurance law.

3303 Section 26. Section **31A-22-412** is amended to read:

3304 **31A-22-412. Assignment of life insurance rights.**

3305 (1) As used in this section, "final termination of a policy" means the day after which an  
3306 insurer will not reinstate a policy without requiring:

3307 (a) evidence of insurability; or  
3308 (b) written application.

3309 ~~[(+)]~~ (2) (a) Except as provided under Subsection ~~[(3)]~~ (4), the owner of any rights in a  
3310 life insurance policy or annuity contract may assign any of those rights, including any right to  
3311 designate a beneficiary and the rights secured under Sections **31A-22-517** through **31A-22-521**

3312 and any other provision of this title.

3313 (b) An assignment, valid under general contract law, vests the assigned rights in the  
3314 assignee, subject, so far as reasonably necessary for the protection of the insurer, to any  
3315 provisions in the insurance policy or annuity contract inserted to protect the insurer against  
3316 double payment or obligation.

3317 ~~[(2)]~~ (3) The rights of a beneficiary under a life insurance policy or annuity contract are  
3318 subordinate to those of an assignee, unless the beneficiary was designated as an irrevocable  
3319 beneficiary prior to the assignment.

3320 ~~[(3)]~~ (4) Assignment of insurance rights may be expressly prohibited by an annuity  
3321 contract which provides annuities as retirement benefits related to employment contracts.

3322 ~~[(4)]~~ (5) (a) ~~[When]~~ After July 1, 1986, when a life insurance policy or annuity is~~;~~  
3323 ~~after July 1, 1986;~~ assigned in writing as security for an indebtedness, the insurer shall~~[-in any~~  
3324 ~~case in which it has received written notice of the assignment, the name and address of the~~  
3325 ~~assignee, and a request for cancellation notice by the assignee,]~~ mail to the assignee a copy of  
3326 any cancellation notice sent with respect to the policy~~[-]~~, if the insurer has received:

3327 (i) written notice of the assignment;

3328 (ii) the name and address of the assignee; and

3329 (iii) a request for assignment notice from the assignee.

3330 (b) An insurer shall mail the cancellation notice described in Subsection (5)(a):

3331 (i) ~~[This notice shall be sent, postage]~~ prepaid, and addressed to the assignee's address  
3332 filed with the insured~~[- The notice shall be mailed];~~

3333 (ii) not less than 10 days ~~[prior to]~~ before the final termination of the policy; and

3334 (iii) each time the insured ~~[has failed or refused]~~ fails or refuses to transmit a premium  
3335 payment to the insurer before the commencement of the policy's grace period.

3336 (c) The insurer may charge the insured directly or charge against the policy the  
3337 reasonable cost of complying with this section, but in no event to exceed \$5 for each notice.

3338 ~~[As used in this section, "final termination of the policy" means the date after which the policy~~  
3339 ~~will not be reinstated by the insurer without requiring evidence of insurability or written~~  
3340 ~~application.]~~

3341 ~~[(5)]~~ (6) In lieu of providing notices to assignees of final termination of the policy  
3342 under Subsection ~~[(4)]~~ (5), an insurer may provide an assignee with an identical copy of all

3343 notices sent to the owner of the life insurance policy, provided these notices comply with the  
3344 other requirements of this title.

3345 Section 27. Section **31A-22-413** is amended to read:

3346 **31A-22-413. Designation of beneficiary.**

3347 (1) Subject to Subsection ~~31A-22-412~~(3), no life insurance policy or annuity  
3348 contract may restrict the right of a policyholder or certificate holder:

3349 (a) to make an irrevocable designation of beneficiary effective immediately or at some  
3350 subsequent time; or

3351 (b) if the designation of beneficiary is not explicitly irrevocable, to change the  
3352 beneficiary without the consent of the previously designated beneficiary. Subsection  
3353 ~~75-6-201~~(1)(c) applies to designations by will or by separate writing.

3354 (2) (a) An insurer may prescribe formalities to be complied with for the change of  
3355 beneficiaries, but those formalities may only be designed for the protection of the insurer.  
3356 Notwithstanding Section ~~75-2-804~~, the insurer discharges its obligation under the insurance  
3357 policy or certificate of insurance if it pays the properly designated beneficiary unless it has  
3358 actual notice of either an assignment or a change in beneficiary designation made pursuant to  
3359 Subsection (1)(b).

3360 (b) The insurer has actual notice if the formalities prescribed by the policy are  
3361 complied with, or if the change in beneficiary has been requested in the form prescribed by the  
3362 insurer and delivered to an agent representing the insurer at least three days prior to payment to  
3363 the earlier properly designated beneficiary.

3364 Section 28. Section **31A-22-505** is amended to read:

3365 **31A-22-505. Association groups.**

3366 (1) A policy is subject to the requirements of this section if the policy is issued as  
3367 policyholder to an association or to the trustees of a fund established, created, or maintained for  
3368 the benefit of members of one or more associations:

3369 (a) with a minimum membership of 100 persons;

3370 (b) with a constitution and bylaws;

3371 (c) having a shared [~~or common purpose that is not primarily a business or customer~~  
3372 ~~relationship; and~~] substantial common purpose that:

3373 (i) is the same profession, trade, occupation, or similar; or

3374 (ii) is by some common economic or representation of interest or genuine  
3375 organizational relationship unrelated to the provision of benefits; and

3376 (d) that has been in active existence for at least two years.

3377 (2) The policy may insure members and employees of the association, employees of the  
3378 members, one or more of the preceding entities, or all of any classes of these named entities for  
3379 the benefit of persons other than the employees' employer, or any officials, representatives,  
3380 trustees, or agents of the employer or association.

3381 (3) (a) The premiums shall be paid by:

3382 (i) the policyholder from funds contributed by the associations[~~by~~];

3383 (ii) employer members, from funds contributed by the covered persons[;]; or

3384 (iii) from any combination of [~~these~~] Subsections (3)(a)(i) and (ii).

3385 (b) Except as provided under Section [31A-22-512](#), a policy on which no part of the  
3386 premium is contributed by the covered persons, specifically for their insurance, is required to  
3387 insure all eligible persons.

3388 Section 29. Section [31A-22-610.5](#) is amended to read:

3389 **[31A-22-610.5. Dependent coverage.](#)**

3390 (1) As used in this section, "child" has the same meaning as defined in Section  
3391 [78B-12-102](#).

3392 (2) (a) Any individual or group accident and health insurance policy or managed care  
3393 organization contract that provides coverage for a policyholder's or certificate holder's  
3394 dependent:

3395 (i) may not terminate coverage of an unmarried dependent by reason of the dependent's  
3396 age before the dependent's 26th birthday; and

3397 (ii) shall, upon application, provide coverage for all unmarried dependents up to age  
3398 26.

3399 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be  
3400 included in the premium on the same basis as other dependent coverage.

3401 (c) This section does not prohibit the employer from requiring the employee to pay all  
3402 or part of the cost of coverage for unmarried dependents.

3403 (d) An individual or group health insurance policy or managed care organization shall  
3404 continue in force coverage for a dependent through the last day of the month in which the

3405 dependent ceases to be a dependent:

3406 (i) if premiums are paid; and

3407 (ii) notwithstanding Sections 31A-22-618.6 and 31A-22-618.7.

3408 (3) (a) When a parent is required by a court or administrative order to provide health  
3409 insurance coverage for a child, an accident and health insurer may not deny enrollment of a  
3410 child under the accident and health insurance plan of the child's parent on the grounds the  
3411 child:

3412 (i) was born out of wedlock and is entitled to coverage under Subsection (4);

3413 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child  
3414 under the custodial parent's policy;

3415 (iii) is not claimed as a dependent on the parent's federal tax return; [~~or~~]

3416 (iv) does not reside with the parent; or

3417 (v) does not reside in the insurer's service area.

3418 (b) A child enrolled as required under Subsection (3)(a)(iv) is subject to the terms of  
3419 the accident and health insurance plan contract pertaining to services received outside of an  
3420 insurer's service area.

3421 (4) When a child has accident and health coverage through an insurer of a noncustodial  
3422 parent, and when requested by the noncustodial or custodial parent, the insurer shall:

3423 (a) provide information to the custodial parent as necessary for the child to obtain  
3424 benefits through that coverage, but the insurer or employer, or the agents or employees of either  
3425 of them, are not civilly or criminally liable for providing information in compliance with this  
3426 Subsection (4)(a), whether the information is provided pursuant to a verbal or written request;

3427 (b) permit the custodial parent or the service provider, with the custodial parent's  
3428 approval, to submit claims for covered services without the approval of the noncustodial  
3429 parent; and

3430 (c) make payments on claims submitted in accordance with Subsection (4)(b) directly  
3431 to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid  
3432 agency.

3433 (5) When a parent is required by a court or administrative order to provide health  
3434 coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

3435 (a) permit the parent to enroll, under the family coverage, a child who is otherwise

3436 eligible for the coverage without regard to an enrollment season restrictions;

3437 (b) if the parent is enrolled but fails to make application to obtain coverage for the  
3438 child, enroll the child under family coverage upon application of the child's other parent, the  
3439 state agency administering the Medicaid program, or the state agency administering 42 U.S.C.  
3440 Sec. 651 through 669, the child support enforcement program; and

3441 (c) (i) when the child is covered by an individual policy, not disenroll or eliminate  
3442 coverage of the child unless the insurer is provided satisfactory written evidence that:

3443 (A) the court or administrative order is no longer in effect; or

3444 (B) the child is or will be enrolled in comparable accident and health coverage through  
3445 another insurer which will take effect not later than the effective date of disenrollment; or

3446 (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of  
3447 the child unless the employer is provided with satisfactory written evidence, which evidence is  
3448 also provided to the insurer, that Subsection (8)(c)(i), (ii), or (iii) has happened.

3449 (6) An insurer may not impose requirements on a state agency that has been assigned  
3450 the rights of an individual eligible for medical assistance under Medicaid and covered for  
3451 accident and health benefits from the insurer that are different from requirements applicable to  
3452 an agent or assignee of any other individual so covered.

3453 (7) Insurers may not reduce their coverage of pediatric vaccines below the benefit level  
3454 in effect on May 1, 1993.

3455 (8) When a parent is required by a court or administrative order to provide health  
3456 coverage, which is available through an employer doing business in this state, the employer  
3457 shall:

3458 (a) permit the parent to enroll under family coverage any child who is otherwise  
3459 eligible for coverage without regard to any enrollment season restrictions;

3460 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,  
3461 enroll the child under family coverage upon application by the child's other parent, by the state  
3462 agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec.  
3463 651 through 669, the child support enforcement program;

3464 (c) not disenroll or eliminate coverage of the child unless the employer is provided  
3465 satisfactory written evidence that:

3466 (i) the court order is no longer in effect;



3467 (ii) the child is or will be enrolled in comparable coverage which will take effect no  
3468 later than the effective date of disenrollment; or

3469 (iii) the employer has eliminated family health coverage for all of its employees; and

3470 (d) withhold from the employee's compensation the employee's share, if any, of  
3471 premiums for health coverage and to pay this amount to the insurer.

3472 (9) An order issued under Section [62A-11-326.1](#) may be considered a "qualified  
3473 medical support order" for the purpose of enrolling a dependent child in a group accident and  
3474 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income  
3475 Security Act of 1974.

3476 (10) This section does not affect any insurer's ability to require as a precondition of any  
3477 child being covered under any policy of insurance that:

3478 (a) the parent continues to be eligible for coverage;

3479 (b) the child shall be identified to the insurer with adequate information to comply with  
3480 this section; and

3481 (c) the premium shall be paid when due.

3482 (11) This section applies to employee welfare benefit plans as defined in Section  
3483 [26-19-102](#).

3484 (12) (a) A policy that provides coverage to a child of a group member may not deny  
3485 eligibility for coverage to a child solely because:

3486 (i) the child does not reside with the insured; or

3487 (ii) the child is solely dependent on a former spouse of the insured rather than on the  
3488 insured.

3489 (b) A child who does not reside with the insured may be excluded on the same basis as  
3490 a child who resides with the insured.

3491 Section 30. Section [31A-22-615.5](#) is amended to read:

3492 **31A-22-615.5. Insurance coverage for opioids -- Policies -- Reports.**

3493 (1) For purposes of this section:

3494 (a) "Health care provider" means an individual, other than a veterinarian, who:

3495 (i) is licensed to prescribe a controlled substance under Title 58, Chapter 37, Utah  
3496 Controlled Substances Act; and

3497 (ii) possesses the authority, in accordance with the individual's scope of practice, to

3498 prescribe Schedule II controlled substances and Schedule III controlled substances that are  
3499 applicable to opioids and benzodiazapines.

3500 (b) "Health insurer" means:

3501 (i) an insurer who offers health care insurance as that term is defined in Section

3502 [31A-1-301](#);

3503 (ii) health benefits offered to state employees under Section [49-20-202](#); and

3504 (iii) a workers' compensation insurer:

3505 (A) authorized to provide workers' compensation insurance in the state; or

3506 (B) that is a self-insured employer as [~~defined~~] described in Section [34A-2-201](#).

3507 (c) "Opioid" has the same meaning as "opiate," as that term is defined in Section

3508 [58-37-2](#).

3509 (d) "Prescribing policy" means a policy developed by a health insurer that includes  
3510 evidence based guidelines for prescribing opioids, and may include the 2016 Center for Disease  
3511 Control Guidelines for Prescribing Opioids for Chronic Pain, or the Utah Clinical Guidelines  
3512 on Prescribing Opioids for the treatment of pain.

3513 (2) A health insurer that provides prescription drug coverage may enact a policy to  
3514 minimize the risk of opioid addiction and overdose from:

3515 (a) chronic co-prescription of opioids with benzodiazapines and other sedating  
3516 substances;

3517 (b) prescription of very high dose opioids in the primary care setting; and

3518 (c) the inadvertent transition of short-term opioids for an acute injury into long-term  
3519 opioid dependence.

3520 (3) A health insurer that provides prescription drug coverage may enact policies to  
3521 facilitate:

3522 (a) non-narcotic treatment alternatives for patients who have chronic pain; and

3523 (b) medication-assisted treatment for patients who have opioid dependence disorder.

3524 (4) The requirements of this section apply to insurance plans entered into or renewed  
3525 on or after July 1, 2017.

3526 (5) (a) A health insurer subject to this section shall on or before [~~September 1, 2017~~]  
3527 July 15, 2020, and before each [~~September 1~~] July 15 thereafter, submit a written report to the  
3528 Utah Insurance Department regarding whether the insurer has adopted a policy and a general

3529 description of the policy.

3530 (b) The Utah Insurance Department shall, on or before October 1, 2017, and before  
3531 each October 1 thereafter, submit a written summary of the information under Subsection (5)(a)  
3532 to the Health and Human Services Interim Committee.

3533 (6) A health insurer subject to this section may share the policies developed under this  
3534 section with other health insurers and the public.

3535 (7) This section sunsets in accordance with Section [63I-1-231](#).  
3536 Section 31. Section **31A-22-2001** is enacted to read:

3537 **Part 20. Limited Long-Term Care Insurance Act**

3538 **31A-22-2001. Title.**

3539 This part is known as the "Limited Long-Term Care Insurance Act."

3540 Section 32. Section **31A-22-2002** is enacted to read:

3541 **31A-22-2002. Definitions.**

3542 As used in this part:

3543 (1) "Applicant" means:

3544 (a) when referring to an individual limited long-term care insurance policy, the person  
3545 who seeks to contract for benefits; and

3546 (b) when referring to a group limited long-term care insurance policy, the proposed  
3547 certificate holder.

3548 (2) "Elimination period" means the length of time between meeting the eligibility for  
3549 benefit payment and receiving benefit payments from an insurer.

3550 (3) "Group limited long-term care insurance" means a limited long-term care insurance  
3551 policy that is delivered or issued for delivery:

3552 (a) in this state; and

3553 (b) to an eligible group, as described under Subsection [31A-22-701\(2\)](#).

3554 (4) (a) "Limited long-term care insurance" means an insurance:

3555 (i) policy, endorsement, or rider that is advertised, marketed, offered, or designed to  
3556 provide coverage:

3557 (A) for less than 12 consecutive months for each covered person;

3558 (B) on an expense-incurred, indemnity, prepaid or other basis; and

3559 (C) for one or more necessary or medically necessary diagnostic, preventative,

3560 therapeutic, rehabilitative, maintenance, or personal care services that is provided in a setting  
3561 other than an acute care unit of a hospital; or

3562 (ii) policy or rider that provides for payment of benefits based on cognitive impairment  
3563 or the loss of functional capacity.

3564 (b) "Limited long-term care insurance" does not include an insurance policy that is  
3565 offered primarily to provide:

3566 (i) basic Medicare supplement coverage;

3567 (ii) basic hospital expense coverage;

3568 (iii) basic medical-surgical expense coverage;

3569 (iv) hospital confinement indemnity coverage;

3570 (v) major medical expense coverage;

3571 (vi) disability income or related asset-protection coverage;

3572 (vii) accidental only coverage;

3573 (viii) specified disease or specified accident coverage; or

3574 (ix) limited benefit health coverage.

3575 (5) "Preexisting condition" means a condition for which medical advice or treatment is  
3576 recommended:

3577 (a) by, or received from, a provider of health care services; and

3578 (b) within six months before the day on which the coverage of an insured person  
3579 becomes effective.

3580 (6) "Waiting period" means the time an insured waits before some or all of the  
3581 insured's coverage becomes effective.

3582 Section 33. Section **31A-22-2003** is enacted to read:

3583 **31A-22-2003. Scope.**

3584 (1) The requirements of this part apply to limited long-term care insurance policies and  
3585 certificates marketed, delivered, or issued for delivery in this state on or after July 1, 2020.

3586 (2) Laws and regulations designed or intended to apply to Medicare supplement  
3587 insurance policies may not be applied to limited long-term care insurance.

3588 Section 34. Section **31A-22-2004** is enacted to read:

3589 **31A-22-2004. Disclosure and performance standards for limited long-term care**  
3590 **insurance.**

- 3591 (1) A limited long-term care insurance policy may not:  
3592 (a) be cancelled, nonrenewed, or otherwise terminated because of the age, gender, or  
3593 the deterioration of the mental or physical health of the insured individual or certificate holder;  
3594 (b) contain a provision establishing a new waiting period if existing coverage is  
3595 converted to or replaced by a new or other form within the same insurer, or the insurer's  
3596 affiliates, except with respect to an increase in benefits voluntarily selected by the insured  
3597 individual or group policyholder; or  
3598 (c) provide coverage for skilled nursing care only or provide significantly more  
3599 coverage for skilled care in a facility than coverage for lower levels of care.
- 3600 (2) (a) A limited long-term care insurance policy or certificate may not:  
3601 (i) use a definition of "preexisting condition" that is more restrictive than the definition  
3602 under this part; or  
3603 (ii) exclude coverage for a loss or confinement that is the result of a preexisting  
3604 condition, unless the loss or confinement begins within six months after the day on which the  
3605 coverage of the insured person becomes effective.
- 3606 (b) A preexisting condition does not prohibit an insurer from:  
3607 (i) using an application form designed to elicit the complete health history of an  
3608 applicant; or  
3609 (ii) on the basis of the answers on the application described in Subsection (2)(c)(i),  
3610 underwriting in accordance with the insurer's established underwriting standards.
- 3611 (c) (i) Unless otherwise provided in the policy or certificate, an insurer may exclude  
3612 coverage of a preexisting condition:  
3613 (A) for a time period of six months, beginning the day on which the coverage of the  
3614 insured person becomes effective; and  
3615 (B) regardless of whether the preexisting condition is disclosed on the application.
- 3616 (ii) A limited long-term care insurance policy or certificate may not exclude or use  
3617 waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically  
3618 named or described preexisting diseases or physical conditions for more than a time period of  
3619 six months, beginning the day on which the coverage of the insured person becomes effective.
- 3620 (3) (a) An insurer may not deliver or issue for delivery a limited long-term care  
3621 insurance policy that conditions eligibility for any benefits:

3622 (i) on a prior hospitalization requirement;  
3623 (ii) provided in an institutional care setting, on the receipt of a higher level of  
3624 institutional care; or  
3625 (iii) other than waiver of premium, post-confinement, post-acute care, or recuperative  
3626 benefits, on a prior institutionalization requirement.  
3627 (b) A limited long-term care insurance policy or rider may not condition eligibility for  
3628 noninstitutional benefits on the prior or continuing receipt of skilled care services.  
3629 (4) (a) If, after examination of a policy, certificate, or rider, a limited long-term care  
3630 insurance applicant is not satisfied for any reason, the applicant has the right to:  
3631 (i) within 30 days after the day on which the applicant receives the policy, certificate,  
3632 endorsement, or rider, return the policy, certificate, endorsement, or rider to the company or a  
3633 producer of the company; and  
3634 (ii) have the premium refunded.  
3635 (b) (i) Each limited long-term care insurance policy, certificate, endorsement, and rider  
3636 shall:  
3637 (A) have a notice prominently printed on the first page or attached thereto detailing  
3638 specific instructions to accomplish a return; and  
3639 (B) include the following free-look statement or language substantially similar: "You  
3640 have 30 days from the day on which you receive this policy certificate, endorsement, or rider to  
3641 review it and return it to the company if you decide not to keep it. You do not have to tell the  
3642 company why you are returning it. If you decide not to keep it, simply return it to the company  
3643 at its administrative office. Or you may return it to the producer that you bought it from. You  
3644 must return it within 30 days of the day you first received it. The company will refund the full  
3645 amount of any premium paid within 30 days after it receives the returned policy, certificate, or  
3646 rider. The premium refund will be sent directly to the person who paid it. The policy certificate  
3647 or rider will be void as if it had never been issued."  
3648 (ii) The requirements described in Subsection (4)(b)(i) do not apply to a certificate  
3649 issued to an employee under an employer group limited long-term care insurance policy.  
3650 (5) (a) (i) An insurer shall deliver an outline of coverage to a prospective applicant for  
3651 limited long-term care insurance at the time of initial solicitation through means that  
3652 prominently direct the attention of the recipient to the document and the document's purpose.

3653 (ii) In the case of an agent solicitation, the agent shall deliver the outline of coverage  
3654 before the presentation of an application or enrollment form.

3655 (iii) In the case of a direct response solicitation, the outline of coverage shall be  
3656 presented in conjunction with any application or enrollment form.

3657 (iv) (A) In the case of a policy issued to a group, the outline of coverage is not required  
3658 to be delivered if the information described in Subsections (5)(b)(i) through (iii) is contained in  
3659 other materials relating to enrollment, including the certificate.

3660 (B) Upon request, an insurer shall make the other materials described in this  
3661 Subsection (5)(a)(iv) available to the commissioner.

3662 (b) An outline of coverage shall include:

3663 (i) a description of the principal benefits and coverage provided in the policy;

3664 (ii) a description of the eligibility triggers for benefits and how the eligibility triggers  
3665 are met;

3666 (iii) a statement of the principal exclusions, reductions, and limitations contained in the  
3667 policy;

3668 (iv) a statement of the terms under which the policy or certificate, or both, may be  
3669 continued in force or discontinued, including any reservation in the policy of a right to change  
3670 premium.

3671 (v) a specific description of each continuation or conversion provision of group  
3672 coverage;

3673 (vi) a statement that the outline of coverage is a summary only, not a contract of  
3674 insurance, and that the policy or group master policy contains governing contractual provisions;

3675 (vii) a description of the terms under which a person may return the policy or  
3676 certificate and have the premium refunded;

3677 (viii) a brief description of the relationship of cost of care and benefits; and

3678 (ix) a statement that discloses to the policyholder or certificate holder that the policy is  
3679 not long-term care insurance.

3680 (6) A certificate pursuant to a group limited long-term care insurance policy that is  
3681 delivered or issued for delivery in this state shall include:

3682 (a) a description of the principal benefits and coverage provided in the policy;

3683 (b) a statement of the principal exclusions, reductions, and limitations contained in the

3684 policy; and

3685 (c) a statement that the group master policy determines governing contractual  
3686 provisions.

3687 (7) If an application for a limited long-term care insurance contract or certificate is  
3688 approved, the issuer shall deliver the contract or certificate of insurance to the applicant no  
3689 later than 30 days after the day on which the application is approved.

3690 Section 35. Section **31A-22-2005** is enacted to read:

3691 **31A-22-2005. Nonforfeiture benefits.**

3692 (1) (a) A limited long-term care insurance policy may offer the option of purchasing a  
3693 policy or certificate including a nonforfeiture benefit.

3694 (b) The offer of a nonforfeiture benefit may be in the form of a rider that is attached to  
3695 the policy.

3696 (c) In the event the policy holder or certificate holder does not purchase a nonforfeiture  
3697 benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a  
3698 specified period of time following a substantial increase in premium rates.

3699 (2) If an insurer issues a group limited long-term care insurance policy, the insurer  
3700 shall:

3701 (a) make any offer of a nonforfeiture benefit to the group policyholder; and

3702 (b) make any offer to each proposed certificate holder.

3703 Section 36. Section **31A-22-2006** is enacted to read:

3704 **31A-22-2006. Rulemaking.**

3705 In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
3706 commissioner:

3707 (1) shall makes rules:

3708 (a) in the event of a substantial rate increase, promoting premium adequacy and  
3709 protecting the policy holder;

3710 (b) establishing minimum standards for limited long-term care insurance marketing  
3711 practices, producer compensation, producer testing, independent review of benefit  
3712 determinations, penalties, and reporting practices;

3713 (c) prescribing a standard format, including style, arrangement, and overall appearance  
3714 of an outline of coverage;



- 3715 (d) prescribing the content of an outline of coverage, in accordance with the  
3716 requirements described in Subsection 31A-22-2004(5)(b);
- 3717 (e) specifying the type of nonforfeiture benefits offered as part of a limited long-term  
3718 care insurance policy or certificate;
- 3719 (f) establishing the standards of nonforfeiture benefits; and
- 3720 (g) establishing the rules regarding contingent benefits upon lapse, including:
- 3721 (i) a determination of the specified period of time during which a contingent benefit  
3722 upon lapse will be available; and
- 3723 (ii) the substantial premium rate increase that triggers a contingent benefit upon lapse  
3724 as described in Subsection 31A-22-2005(1); and
- 3725 (2) may make rules establishing loss-ratio standards for limited long-term care  
3726 insurance policies.

3727 Section 37. Section 31A-23a-111 is amended to read:

3728 **31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
3729 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**

3730 (1) A license type issued under this chapter remains in force until:

3731 (a) revoked or suspended under Subsection (5);

3732 (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
3733 administrative action;

3734 (c) the licensee dies or is adjudicated incompetent as defined under:

3735 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3736 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
3737 Minors;

3738 (d) lapsed under Section 31A-23a-113; or

3739 (e) voluntarily surrendered.

3740 (2) The following may be reinstated within one year after the day on which the license  
3741 is no longer in force:

3742 (a) a lapsed license; or

3743 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
3744 not be reinstated after the license period in which the license is voluntarily surrendered.

3745 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a

3746 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
3747 department from pursuing additional disciplinary or other action authorized under:

3748 (a) this title; or

3749 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah

3750 Administrative Rulemaking Act.

3751 (4) A line of authority issued under this chapter remains in force until:

3752 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;

3753 or

3754 (b) the supporting license type:

3755 (i) is revoked or suspended under Subsection (5);

3756 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of

3757 administrative action;

3758 (iii) lapses under Section [31A-23a-113](#); or

3759 (iv) is voluntarily surrendered; or

3760 (c) the licensee dies or is adjudicated incompetent as defined under:

3761 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3762 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and

3763 Minors.

3764 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an

3765 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the

3766 commissioner may:

3767 (i) revoke:

3768 (A) a license; or

3769 (B) a line of authority;

3770 (ii) suspend for a specified period of 12 months or less:

3771 (A) a license; or

3772 (B) a line of authority;

3773 (iii) limit in whole or in part:

3774 (A) a license; or

3775 (B) a line of authority;

3776 (iv) deny a license application;

- 3777 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or  
3778 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and  
3779 Subsection (5)(a)(v).
- 3780 (b) The commissioner may take an action described in Subsection (5)(a) if the  
3781 commissioner finds that the licensee or license applicant:
- 3782 (i) is unqualified for a license or line of authority under Section 31A-23a-104,  
3783 31A-23a-105, or 31A-23a-107;
- 3784 (ii) violates:
- 3785 (A) an insurance statute;
- 3786 (B) a rule that is valid under Subsection 31A-2-201(3); or  
3787 (C) an order that is valid under Subsection 31A-2-201(4);
- 3788 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other  
3789 delinquency proceedings in any state;
- 3790 (iv) fails to pay a final judgment rendered against the person in this state within 60  
3791 days after the day on which the judgment became final;
- 3792 (v) fails to meet the same good faith obligations in claims settlement that is required of  
3793 admitted insurers;
- 3794 (vi) is affiliated with and under the same general management or interlocking  
3795 directorate or ownership as another insurance producer that transacts business in this state  
3796 without a license;
- 3797 (vii) refuses:
- 3798 (A) to be examined; or  
3799 (B) to produce its accounts, records, and files for examination;
- 3800 (viii) has an officer who refuses to:
- 3801 (A) give information with respect to the insurance producer's affairs; or  
3802 (B) perform any other legal obligation as to an examination;
- 3803 (ix) provides information in the license application that is:
- 3804 (A) incorrect;  
3805 (B) misleading;  
3806 (C) incomplete; or  
3807 (D) materially untrue;

- 3808 (x) violates an insurance law, valid rule, or valid order of another regulatory agency in  
3809 any jurisdiction;
- 3810 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
- 3811 (xii) improperly withholds, misappropriates, or converts money or properties received  
3812 in the course of doing insurance business;
- 3813 (xiii) intentionally misrepresents the terms of an actual or proposed:
- 3814 (A) insurance contract;
- 3815 (B) application for insurance; or
- 3816 (C) life settlement;
- 3817 (xiv) has been convicted of:
- 3818 (A) a felony; or
- 3819 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
- 3820 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
- 3821 (xvi) in the conduct of business in this state or elsewhere:
- 3822 (A) uses fraudulent, coercive, or dishonest practices; or
- 3823 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
- 3824 (xvii) has had an insurance license or other professional or occupational license, or an  
3825 equivalent to an insurance license or registration, or other professional or occupational license  
3826 or registration:
- 3827 (A) denied;
- 3828 (B) suspended;
- 3829 (C) revoked; or
- 3830 (D) surrendered to resolve an administrative action;
- 3831 (xviii) forges another's name to:
- 3832 (A) an application for insurance; or
- 3833 (B) a document related to an insurance transaction;
- 3834 (xix) improperly uses notes or another reference material to complete an examination  
3835 for an insurance license;
- 3836 (xx) knowingly accepts insurance business from an individual who is not licensed;
- 3837 (xxi) fails to comply with an administrative or court order imposing a child support  
3838 obligation;

- 3839 (xxii) fails to:
- 3840 (A) pay state income tax; or
- 3841 (B) comply with an administrative or court order directing payment of state income
- 3842 tax;
- 3843 (xxiii) has been convicted of violating the federal Violent Crime Control and Law
- 3844 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage
- 3845 in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;
- 3846 (xxiv) engages in a method or practice in the conduct of business that endangers the
- 3847 legitimate interests of customers and the public; or
- 3848 (xxv) has been convicted of any criminal felony involving dishonesty or breach of trust
- 3849 and has not obtained written consent to engage in the business of insurance or participate in
- 3850 such business as required by 18 U.S.C. Sec. 1033.
- 3851 (c) For purposes of this section, if a license is held by an agency, both the agency itself
- 3852 and any individual designated under the license are considered to be the holders of the license.
- 3853 (d) If an individual designated under the agency license commits an act or fails to
- 3854 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
- 3855 the commissioner may suspend, revoke, or limit the license of:
- 3856 (i) the individual;
- 3857 (ii) the agency, if the agency:
- 3858 (A) is reckless or negligent in its supervision of the individual; or
- 3859 (B) knowingly participates in the act or failure to act that is the ground for suspending,
- 3860 revoking, or limiting the license; or
- 3861 (iii) (A) the individual; and
- 3862 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
- 3863 (6) A licensee under this chapter is subject to the penalties for acting as a licensee
- 3864 without a license if:
- 3865 (a) the licensee's license is:
- 3866 (i) revoked;
- 3867 (ii) suspended;
- 3868 (iii) limited;
- 3869 (iv) surrendered in lieu of administrative action;

3870 (v) lapsed; or  
3871 (vi) voluntarily surrendered; and  
3872 (b) the licensee:  
3873 (i) continues to act as a licensee; or  
3874 (ii) violates the terms of the license limitation.  
3875 (7) A licensee under this chapter shall immediately report to the commissioner:  
3876 (a) a revocation, suspension, or limitation of the person's license in another state, the  
3877 District of Columbia, or a territory of the United States;  
3878 (b) the imposition of a disciplinary sanction imposed on that person by another state,  
3879 the District of Columbia, or a territory of the United States; or  
3880 (c) a judgment or injunction entered against that person on the basis of conduct  
3881 involving:  
3882 (i) fraud;  
3883 (ii) deceit;  
3884 (iii) misrepresentation; or  
3885 (iv) a violation of an insurance law or rule.  
3886 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a  
3887 license in lieu of administrative action may specify a time, not to exceed five years, within  
3888 which the former licensee may not apply for a new license.  
3889 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the  
3890 former licensee may not apply for a new license for five years from the day on which the order  
3891 or agreement is made without the express approval by the commissioner.  
3892 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
3893 a license issued under this part if so ordered by a court.  
3894 (10) The commissioner shall by rule prescribe the license renewal and reinstatement  
3895 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.  
3896 Section 38. Section **31A-23a-205** is amended to read:  
3897 **31A-23a-205. Special requirements for bail bond producers and bail bond**  
3898 **enforcement agents.**  
3899 (1) As used in this section, "bail bond producer" and "bail enforcement agent" have the  
3900 same definitions as in Section [31A-35-102](#).

3901 (2) A bail bond producer may not operate in this state without an appointment from  
3902 one or more authorized bail bond surety insurers or licensed bail bond [surety] companies.

3903 (3) A bail bond enforcement agent may not operate in this state without an appointment  
3904 from one or more licensed bail bond producers.

3905 Section 39. Section **31A-23a-415** is amended to read:

3906 **31A-23a-415. Assessment on agency title insurance producers or title insurers --**  
3907 **Account created.**

3908 (1) For purposes of this section:

3909 (a) "Premium" is as [~~defined~~] described in Subsection [59-9-101\(3\)](#).

3910 (b) "Title insurer" means a person:

3911 (i) making any contract or policy of title insurance as:

3912 (A) insurer;

3913 (B) guarantor; or

3914 (C) surety;

3915 (ii) proposing to make any contract or policy of title insurance as:

3916 (A) insurer;

3917 (B) guarantor; or

3918 (C) surety; or

3919 (iii) transacting or proposing to transact any phase of title insurance, including:

3920 (A) soliciting;

3921 (B) negotiating preliminary to execution;

3922 (C) executing of a contract of title insurance;

3923 (D) insuring; and

3924 (E) transacting matters subsequent to the execution of the contract and arising out of  
3925 the contract.

3926 (c) "Utah risks" means insuring, guaranteeing, or indemnifying with regard to real or  
3927 personal property located in Utah, an owner of real or personal property, the holders of liens or  
3928 encumbrances on that property, or others interested in the property against loss or damage  
3929 suffered by reason of:

3930 (i) liens or encumbrances upon, defects in, or the unmarketability of the title to the  
3931 property; or

3932 (ii) invalidity or unenforceability of any liens or encumbrances on the property.

3933 (2) (a) The commissioner may assess each title insurer, each individual title insurance  
3934 producer who is not an employee of a title insurer or who is not designated by an agency title  
3935 insurance producer, and each agency title insurance producer an annual assessment:

3936 (i) determined by the Title and Escrow Commission:

3937 (A) after consultation with the commissioner; and

3938 (B) in accordance with this Subsection (2); and

3939 (ii) to be used for the purposes described in Subsection (3).

3940 (b) An agency title insurance producer and individual title insurance producer who is  
3941 not an employee of a title insurer or who is not designated by an agency title insurance  
3942 producer shall be assessed up to:

3943 (i) \$250 for the first office in each county in which the agency title insurance producer  
3944 or individual title insurance producer maintains an office; and

3945 (ii) \$150 for each additional office the agency title insurance producer or individual  
3946 title insurance producer maintains in the county described in Subsection (2)(b)(i).

3947 (c) A title insurer shall be assessed up to:

3948 (i) \$250 for the first office in each county in which the title insurer maintains an office;

3949 (ii) \$150 for each additional office the title insurer maintains in the county described in  
3950 Subsection (2)(c)(i); and

3951 (iii) an amount calculated by:

3952 (A) aggregating the assessments imposed on:

3953 (I) agency title insurance producers and individual title insurance producers under  
3954 Subsection (2)(b); and

3955 (II) title insurers under Subsections (2)(c)(i) and (2)(c)(ii);

3956 (B) subtracting the amount determined under Subsection (2)(c)(iii)(A) from the total  
3957 costs and expenses determined under Subsection (2)(d); and

3958 (C) multiplying:

3959 (I) the amount calculated under Subsection (2)(c)(iii)(B); and

3960 (II) the percentage of total premiums for title insurance on Utah risk that are premiums  
3961 of the title insurer.

3962 (d) Notwithstanding Section 31A-3-103 and subject to Section 31A-2-404, the Title



3963 and Escrow Commission by rule shall establish the amount of costs and expenses described  
3964 under Subsection (3) that will be covered by the assessment, except the costs or expenses to be  
3965 covered by the assessment may not exceed [~~\$100,000 annually~~] the cost of one full-time  
3966 equivalent position.

3967 (e) (i) An individual licensed to practice law in Utah is exempt from the requirements  
3968 of this Subsection (2) if that person issues 12 or less policies during a 12-month period.

3969 (ii) In determining the number of policies issued by an individual licensed to practice  
3970 law in Utah for purposes of Subsection (2)(e)(i), if the individual issues a policy to more than  
3971 one party to the same closing, the individual is considered to have issued only one policy.

3972 (3) (a) Money received by the state under this section shall be deposited into the Title  
3973 Licensee Enforcement Restricted Account.

3974 (b) There is created in the General Fund a restricted account known as the "Title  
3975 Licensee Enforcement Restricted Account."

3976 (c) The Title Licensee Enforcement Restricted Account shall consist of the money  
3977 received by the state under this section.

3978 (d) The commissioner shall administer the Title Licensee Enforcement Restricted  
3979 Account. Subject to appropriations by the Legislature, the commissioner shall use the money  
3980 deposited into the Title Licensee Enforcement Restricted Account only to pay for a cost or  
3981 expense incurred by the department in the administration, investigation, and enforcement of  
3982 laws governing individual title insurance producers, agency title insurance producers, or title  
3983 insurers.

3984 (e) An appropriation from the Title Licensee Enforcement Restricted Account is  
3985 nonlapsing.

3986 (4) The assessment imposed by this section shall be in addition to any premium  
3987 assessment imposed under Subsection 59-9-101(3).

3988 Section 40. Section **31A-23b-401** is amended to read:

3989 **31A-23b-401. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
3990 **terminating a license -- Rulemaking for renewal or reinstatement.**

3991 (1) A license as a navigator under this chapter remains in force until:

3992 (a) revoked or suspended under Subsection (4);

3993 (b) surrendered to the commissioner and accepted by the commissioner in lieu of

3994 administrative action;

3995 (c) the licensee dies or is adjudicated incompetent as defined under:

3996 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3997 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and

3998 Minors;

3999 (d) lapsed under this section; or

4000 (e) voluntarily surrendered.

4001 (2) The following may be reinstated within one year after the day on which the license

4002 is no longer in force:

4003 (a) a lapsed license; or

4004 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may

4005 not be reinstated after the license period in which the license is voluntarily surrendered.

4006 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a

4007 license, submission and acceptance of a voluntary surrender of a license does not prevent the

4008 department from pursuing additional disciplinary or other action authorized under:

4009 (a) this title; or

4010 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah

4011 Administrative Rulemaking Act.

4012 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an

4013 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the

4014 commissioner may:

4015 (i) revoke a license;

4016 (ii) suspend a license for a specified period of 12 months or less;

4017 (iii) limit a license in whole or in part;

4018 (iv) deny a license application;

4019 (v) assess a forfeiture under Subsection [31A-2-308\(1\)\(b\)\(i\)](#) or [\(1\)\(c\)\(i\)](#); or

4020 (vi) take a combination of actions under Subsections (4)(a)(i) through (iv) and

4021 Subsection (4)(a)(v).

4022 (b) The commissioner may take an action described in Subsection (4)(a) if the

4023 commissioner finds that the licensee or license applicant:

4024 (i) is unqualified for a license under Section [31A-23b-204](#), [31A-23b-205](#), or

- 4025 31A-23b-206;
- 4026 (ii) violated:
- 4027 (A) an insurance statute;
- 4028 (B) a rule that is valid under Subsection 31A-2-201(3); or
- 4029 (C) an order that is valid under Subsection 31A-2-201(4);
- 4030 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
- 4031 delinquency proceedings in any state;
- 4032 (iv) failed to pay a final judgment rendered against the person in this state within 60
- 4033 days after the day on which the judgment became final;
- 4034 (v) refused:
- 4035 (A) to be examined; or
- 4036 (B) to produce its accounts, records, and files for examination;
- 4037 (vi) had an officer who refused to:
- 4038 (A) give information with respect to the navigator's affairs; or
- 4039 (B) perform any other legal obligation as to an examination;
- 4040 (vii) provided information in the license application that is:
- 4041 (A) incorrect;
- 4042 (B) misleading;
- 4043 (C) incomplete; or
- 4044 (D) materially untrue;
- 4045 (viii) violated an insurance law, valid rule, or valid order of another regulatory agency
- 4046 in any jurisdiction;
- 4047 (ix) obtained or attempted to obtain a license through misrepresentation or fraud;
- 4048 (x) improperly withheld, misappropriated, or converted money or properties received
- 4049 in the course of doing insurance business;
- 4050 (xi) intentionally misrepresented the terms of an actual or proposed:
- 4051 (A) insurance contract;
- 4052 (B) application for insurance; or
- 4053 (C) application for public program;
- 4054 (xii) has been convicted of:
- 4055 (A) a felony; or

4056 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;  
4057 (xiii) admitted or is found to have committed an insurance unfair trade practice or  
4058 fraud;  
4059 (xiv) in the conduct of business in this state or elsewhere:  
4060 (A) used fraudulent, coercive, or dishonest practices; or  
4061 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;  
4062 (xv) has had an insurance license, navigator license, or other professional or  
4063 occupational license or registration, or an equivalent of the same denied, suspended, revoked,  
4064 or surrendered to resolve an administrative action;  
4065 (xvi) forged another's name to:  
4066 (A) an application for insurance;  
4067 (B) a document related to an insurance transaction;  
4068 (C) a document related to an application for a public program; or  
4069 (D) a document related to an application for premium subsidies;  
4070 (xvii) improperly used notes or another reference material to complete an examination  
4071 for a license;  
4072 (xviii) knowingly accepted insurance business from an individual who is not licensed;  
4073 (xix) failed to comply with an administrative or court order imposing a child support  
4074 obligation;  
4075 (xx) failed to:  
4076 (A) pay state income tax; or  
4077 (B) comply with an administrative or court order directing payment of state income  
4078 tax;  
4079 (xxi) has been convicted of violating the federal Violent Crime Control and Law  
4080 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage  
4081 in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;  
4082 (xxii) engaged in a method or practice in the conduct of business that endangered the  
4083 legitimate interests of customers and the public; or  
4084 (xxiii) has been convicted of any criminal felony involving dishonesty or breach of  
4085 trust and has not obtained written consent to engage in the business of insurance or participate  
4086 in such business as required by 18 U.S.C. Sec. 1033.

4087 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
4088 and any individual designated under the license are considered to be the holders of the license.

4089 (d) If an individual designated under the agency license commits an act or fails to  
4090 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
4091 the commissioner may suspend, revoke, or limit the license of:

4092 (i) the individual;

4093 (ii) the agency, if the agency:

4094 (A) is reckless or negligent in its supervision of the individual; or

4095 (B) knowingly participates in the act or failure to act that is the ground for suspending,  
4096 revoking, or limiting the license; or

4097 (iii) (A) the individual; and

4098 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

4099 (5) A licensee under this chapter is subject to the penalties for acting as a licensee  
4100 without a license if:

4101 (a) the licensee's license is:

4102 (i) revoked;

4103 (ii) suspended;

4104 (iii) surrendered in lieu of administrative action;

4105 (iv) lapsed; or

4106 (v) voluntarily surrendered; and

4107 (b) the licensee:

4108 (i) continues to act as a licensee; or

4109 (ii) violates the terms of the license limitation.

4110 (6) A licensee under this chapter shall immediately report to the commissioner:

4111 (a) a revocation, suspension, or limitation of the person's license in another state, the  
4112 District of Columbia, or a territory of the United States;

4113 (b) the imposition of a disciplinary sanction imposed on that person by another state,  
4114 the District of Columbia, or a territory of the United States; or

4115 (c) a judgment or injunction entered against that person on the basis of conduct  
4116 involving:

4117 (i) fraud;

- 4118 (ii) deceit;
- 4119 (iii) misrepresentation; or
- 4120 (iv) a violation of an insurance law or rule.
- 4121 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a
- 4122 license in lieu of administrative action may specify a time, not to exceed five years, within
- 4123 which the former licensee may not apply for a new license.
- 4124 (b) If no time is specified in an order or agreement described in Subsection (7)(a), the
- 4125 former licensee may not apply for a new license for five years from the day on which the order
- 4126 or agreement is made without the express approval of the commissioner.
- 4127 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
- 4128 a license issued under this chapter if so ordered by a court.
- 4129 (9) The commissioner shall by rule prescribe the license renewal and reinstatement
- 4130 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
- 4131 Section 41. Section **31A-25-208** is amended to read:
- 4132 **31A-25-208. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
- 4133 **terminating a license -- Rulemaking for renewal and reinstatement.**
- 4134 (1) A license type issued under this chapter remains in force until:
- 4135 (a) revoked or suspended under Subsection (4);
- 4136 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
- 4137 administrative action;
- 4138 (c) the licensee dies or is adjudicated incompetent as defined under:
- 4139 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
- 4140 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
- 4141 Minors;
- 4142 (d) lapsed under Section [31A-25-210](#); or
- 4143 (e) voluntarily surrendered.
- 4144 (2) The following may be reinstated within one year after the day on which the license
- 4145 is no longer in force:
- 4146 (a) a lapsed license; or
- 4147 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
- 4148 not be reinstated after the license period in which the license is voluntarily surrendered.

4149 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a  
4150 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
4151 department from pursuing additional disciplinary or other action authorized under:

4152 (a) this title; or

4153 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah  
4154 Administrative Rulemaking Act.

4155 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an  
4156 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
4157 commissioner may:

4158 (i) revoke a license;

4159 (ii) suspend a license for a specified period of 12 months or less;

4160 (iii) limit a license in whole or in part; or

4161 (iv) deny a license application.

4162 (b) The commissioner may take an action described in Subsection (4)(a) if the  
4163 commissioner finds that the licensee or license applicant:

4164 (i) is unqualified for a license under Section [31A-25-202](#), [31A-25-203](#), or [31A-25-204](#);

4165 (ii) has violated:

4166 (A) an insurance statute;

4167 (B) a rule that is valid under Subsection [31A-2-201\(3\)](#); or

4168 (C) an order that is valid under Subsection [31A-2-201\(4\)](#);

4169 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other  
4170 delinquency proceedings in any state;

4171 (iv) fails to pay a final judgment rendered against the person in this state within 60  
4172 days after the day on which the judgment became final;

4173 (v) fails to meet the same good faith obligations in claims settlement that is required of  
4174 admitted insurers;

4175 (vi) is affiliated with and under the same general management or interlocking  
4176 directorate or ownership as another third party administrator that transacts business in this state  
4177 without a license;

4178 (vii) refuses:

4179 (A) to be examined; or

- 4180 (B) to produce its accounts, records, and files for examination;
- 4181 (viii) has an officer who refuses to:
- 4182 (A) give information with respect to the third party administrator's affairs; or
- 4183 (B) perform any other legal obligation as to an examination;
- 4184 (ix) provides information in the license application that is:
- 4185 (A) incorrect;
- 4186 (B) misleading;
- 4187 (C) incomplete; or
- 4188 (D) materially untrue;
- 4189 (x) has violated an insurance law, valid rule, or valid order of another regulatory
- 4190 agency in any jurisdiction;
- 4191 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 4192 (xii) has improperly withheld, misappropriated, or converted money or properties
- 4193 received in the course of doing insurance business;
- 4194 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 4195 (A) insurance contract; or
- 4196 (B) application for insurance;
- 4197 (xiv) has been convicted of:
- 4198 (A) a felony; or
- 4199 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
- 4200 (xv) has admitted or been found to have committed an insurance unfair trade practice
- 4201 or fraud;
- 4202 (xvi) in the conduct of business in this state or elsewhere has:
- 4203 (A) used fraudulent, coercive, or dishonest practices; or
- 4204 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 4205 (xvii) has had an insurance license or other professional or occupational license or
- 4206 registration, or an equivalent of the same, denied, suspended, revoked, or surrendered to
- 4207 resolve an administrative action;
- 4208 (xviii) has forged another's name to:
- 4209 (A) an application for insurance; or
- 4210 (B) a document related to an insurance transaction;



- 4211 (xix) has improperly used notes or any other reference material to complete an  
4212 examination for an insurance license;
- 4213 (xx) has knowingly accepted insurance business from an individual who is not  
4214 licensed;
- 4215 (xxi) has failed to comply with an administrative or court order imposing a child  
4216 support obligation;
- 4217 (xxii) has failed to:
- 4218 (A) pay state income tax; or
- 4219 (B) comply with an administrative or court order directing payment of state income  
4220 tax;
- 4221 (xxiii) ~~[has violated or permitted others to violate]~~ is convicted of violating the federal  
4222 Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and [therefore]  
4223 has not obtained written consent to engage in the business of insurance or participate in such  
4224 business as required under 18 U.S.C. Sec. 1033 ~~[is prohibited from engaging in the business of~~  
4225 ~~insurance; or]~~;
- 4226 (xxiv) has engaged in methods and practices in the conduct of business that endanger  
4227 the legitimate interests of customers and the public[-]; or
- 4228 (xxv) has been convicted of a criminal felony involving dishonesty or breach of trust  
4229 and has not obtained written consent to engage in the business of insurance or participate in  
4230 such business as required under 18 U.S.C. Sec. 1033.
- 4231 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
4232 and any individual designated under the license are considered to be the holders of the agency  
4233 license.
- 4234 (d) If an individual designated under the agency license commits an act or fails to  
4235 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
4236 the commissioner may suspend, revoke, or limit the license of:
- 4237 (i) the individual;
- 4238 (ii) the agency if the agency:
- 4239 (A) is reckless or negligent in its supervision of the individual; or
- 4240 (B) knowingly participated in the act or failure to act that is the ground for suspending,  
4241 revoking, or limiting the license; or

- 4242 (iii) (A) the individual; and  
4243 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).  
4244 (5) A licensee under this chapter is subject to the penalties for acting as a licensee  
4245 without a license if:  
4246 (a) the licensee's license is:  
4247 (i) revoked;  
4248 (ii) suspended;  
4249 (iii) limited;  
4250 (iv) surrendered in lieu of administrative action;  
4251 (v) lapsed; or  
4252 (vi) voluntarily surrendered; and  
4253 (b) the licensee:  
4254 (i) continues to act as a licensee; or  
4255 (ii) violates the terms of the license limitation.  
4256 (6) A licensee under this chapter shall immediately report to the commissioner:  
4257 (a) a revocation, suspension, or limitation of the person's license in any other state, the  
4258 District of Columbia, or a territory of the United States;  
4259 (b) the imposition of a disciplinary sanction imposed on that person by any other state,  
4260 the District of Columbia, or a territory of the United States; or  
4261 (c) a judgment or injunction entered against the person on the basis of conduct  
4262 involving:  
4263 (i) fraud;  
4264 (ii) deceit;  
4265 (iii) misrepresentation; or  
4266 (iv) a violation of an insurance law or rule.  
4267 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a  
4268 license in lieu of administrative action may specify a time, not to exceed five years, within  
4269 which the former licensee may not apply for a new license.  
4270 (b) If no time is specified in the order or agreement described in Subsection (7)(a), the  
4271 former licensee may not apply for a new license for five years from the day on which the order  
4272 or agreement is made without the express approval of the commissioner.

4273 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
4274 a license issued under this part if so ordered by the court.

4275 (9) The commissioner shall by rule prescribe the license renewal and reinstatement  
4276 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4277 Section 42. Section **31A-26-206** is amended to read:

4278 **31A-26-206. Continuing education requirements.**

4279 (1) Pursuant to this section, the commissioner shall by rule prescribe continuing  
4280 education requirements for each class of license under Section [31A-26-204](#).

4281 (2) (a) The commissioner shall impose continuing education requirements in  
4282 accordance with a two-year licensing period in which the licensee meets the requirements of  
4283 this Subsection (2).

4284 (b) (i) Except as otherwise provided in this section, the continuing education  
4285 requirements shall require:

4286 (A) that a licensee complete 24 credit hours of continuing education for every two-year  
4287 licensing period;

4288 (B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses;  
4289 and

4290 (C) that the licensee complete at least half of the required hours through classroom  
4291 hours of insurance-related instruction.

4292 (ii) A continuing education hour completed in accordance with Subsection (2)(b)(i)  
4293 may be obtained through:

4294 (A) classroom attendance;

4295 (B) home study;

4296 (C) watching a video recording;

4297 (D) experience credit; or

4298 (E) other methods provided by rule.

4299 (iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is  
4300 required to complete 12 credit hours of continuing education for every two-year licensing  
4301 period, with 3 of the credit hours being ethics courses.

4302 (c) A licensee may obtain continuing education hours at any time during the two-year  
4303 licensing period.

4304 (d) (i) A licensee is exempt from the continuing education requirements of this section  
4305 if:

4306 (A) the licensee was first licensed before December 31, 1982;

4307 (B) the license does not have a continuous lapse for a period of more than one year,  
4308 except for a license for which the licensee has had an exemption approved before May 11,  
4309 2011;

4310 (C) the licensee requests an exemption from the department; and

4311 (D) the department approves the exemption.

4312 (ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is  
4313 not required to apply again for the exemption.

4314 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
4315 commissioner shall by rule:

4316 (i) publish a list of insurance professional designations whose continuing education  
4317 requirements can be used to meet the requirements for continuing education under Subsection  
4318 (2)(b); and

4319 (ii) authorize a professional adjuster association to:

4320 (A) offer a qualified program for a classification of license on a geographically  
4321 accessible basis; and

4322 (B) collect a reasonable fee for funding and administration of a qualified program,  
4323 subject to the review and approval of the commissioner.

4324 (f) (i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and  
4325 administer a qualified program shall reasonably relate to the cost of administering the qualified  
4326 program.

4327 (ii) Nothing in this section shall prohibit a provider of a continuing education program  
4328 or course from charging a fee for attendance at a course offered for continuing education credit.

4329 (iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an  
4330 association program may be less for an association member, on the basis of the member's  
4331 affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

4332 (3) The continuing education requirements of this section apply only to a licensee who  
4333 is an individual.

4334 (4) The continuing education requirements of this section do not apply to a member of

4335 the Utah State Bar.

4336 (5) The commissioner shall designate a course that satisfies the requirements of this  
4337 section, including a course presented by an insurer.

4338 (6) A nonresident adjuster is considered to have satisfied this state's continuing  
4339 education requirements if:

4340 (a) the nonresident adjuster satisfies the nonresident [~~producer's~~] home state's  
4341 continuing education requirements for a licensed insurance adjuster; and

4342 (b) on the same basis the nonresident adjuster's home state considers satisfaction of  
4343 Utah's continuing education requirements for [~~a producer~~] an adjuster as satisfying the  
4344 continuing education requirements of the home state.

4345 (7) A licensee subject to this section shall keep documentation of completing the  
4346 continuing education requirements of this section for two years after the end of the two-year  
4347 licensing period to which the continuing education requirement applies.

4348 Section 43. Section **31A-26-213** is amended to read:

4349 **31A-26-213. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
4350 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**

4351 (1) A license type issued under this chapter remains in force until:

4352 (a) revoked or suspended under Subsection (5);

4353 (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
4354 administrative action;

4355 (c) the licensee dies or is adjudicated incompetent as defined under:

4356 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

4357 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
4358 Minors;

4359 (d) lapsed under Section [31A-26-214.5](#); or

4360 (e) voluntarily surrendered.

4361 (2) The following may be reinstated within one year after the day on which the license  
4362 is no longer in force:

4363 (a) a lapsed license; or

4364 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
4365 not be reinstated after the license period in which it is voluntarily surrendered.

4366 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a  
4367 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
4368 department from pursuing additional disciplinary or other action authorized under:

4369 (a) this title; or

4370 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah  
4371 Administrative Rulemaking Act.

4372 (4) A license classification issued under this chapter remains in force until:

4373 (a) the qualifications pertaining to a license classification are no longer met by the  
4374 licensee; or

4375 (b) the supporting license type:

4376 (i) is revoked or suspended under Subsection (5); or

4377 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of  
4378 administrative action.

4379 (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an  
4380 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
4381 commissioner may:

4382 (i) revoke:

4383 (A) a license; or

4384 (B) a license classification;

4385 (ii) suspend for a specified period of 12 months or less:

4386 (A) a license; or

4387 (B) a license classification;

4388 (iii) limit in whole or in part:

4389 (A) a license; or

4390 (B) a license classification;

4391 (iv) deny a license application;

4392 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

4393 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and  
4394 Subsection (5)(a)(v).

4395 (b) The commissioner may take an action described in Subsection (5)(a) if the  
4396 commissioner finds that the licensee or license applicant:

- 4397 (i) is unqualified for a license or license classification under Section 31A-26-202,  
4398 31A-26-203, 31A-26-204, or 31A-26-205;
- 4399 (ii) has violated:
- 4400 (A) an insurance statute;
- 4401 (B) a rule that is valid under Subsection 31A-2-201(3); or
- 4402 (C) an order that is valid under Subsection 31A-2-201(4);
- 4403 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other  
4404 delinquency proceedings in any state;
- 4405 (iv) fails to pay a final judgment rendered against the person in this state within 60  
4406 days after the judgment became final;
- 4407 (v) fails to meet the same good faith obligations in claims settlement that is required of  
4408 admitted insurers;
- 4409 (vi) is affiliated with and under the same general management or interlocking  
4410 directorate or ownership as another insurance adjuster that transacts business in this state  
4411 without a license;
- 4412 (vii) refuses:
- 4413 (A) to be examined; or
- 4414 (B) to produce its accounts, records, and files for examination;
- 4415 (viii) has an officer who refuses to:
- 4416 (A) give information with respect to the insurance adjuster's affairs; or
- 4417 (B) perform any other legal obligation as to an examination;
- 4418 (ix) provides information in the license application that is:
- 4419 (A) incorrect;
- 4420 (B) misleading;
- 4421 (C) incomplete; or
- 4422 (D) materially untrue;
- 4423 (x) has violated an insurance law, valid rule, or valid order of another regulatory  
4424 agency in any jurisdiction;
- 4425 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 4426 (xii) has improperly withheld, misappropriated, or converted money or properties  
4427 received in the course of doing insurance business;

- 4428 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 4429 (A) insurance contract; or
- 4430 (B) application for insurance;
- 4431 (xiv) has been convicted of:
- 4432 (A) a felony; or
- 4433 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
- 4434 (xv) has admitted or been found to have committed an insurance unfair trade practice
- 4435 or fraud;
- 4436 (xvi) in the conduct of business in this state or elsewhere has:
- 4437 (A) used fraudulent, coercive, or dishonest practices; or
- 4438 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 4439 (xvii) has had an insurance license or other professional or occupational license or
- 4440 registration, or equivalent, denied, suspended, revoked, or surrendered to resolve an
- 4441 administrative action;
- 4442 (xviii) has forged another's name to:
- 4443 (A) an application for insurance; or
- 4444 (B) a document related to an insurance transaction;
- 4445 (xix) has improperly used notes or any other reference material to complete an
- 4446 examination for an insurance license;
- 4447 (xx) has knowingly accepted insurance business from an individual who is not
- 4448 licensed;
- 4449 (xxi) has failed to comply with an administrative or court order imposing a child
- 4450 support obligation;
- 4451 (xxii) has failed to:
- 4452 (A) pay state income tax; or
- 4453 (B) comply with an administrative or court order directing payment of state income
- 4454 tax;
- 4455 (xxiii) has been convicted of a violation of the federal Violent Crime Control and Law
- 4456 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent in
- 4457 accordance with 18 U.S.C. Sec. 1033 to engage in the business of insurance or participate in
- 4458 such business;



4459 (xxiv) has engaged in methods and practices in the conduct of business that endanger  
4460 the legitimate interests of customers and the public; or

4461 (xxv) has been convicted of any criminal felony involving dishonesty or breach of trust  
4462 and has not obtained written consent in accordance with 18 U.S.C. Sec. 1033 to engage in the  
4463 business of insurance or participate in such business.

4464 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
4465 and any individual designated under the license are considered to be the holders of the license.

4466 (d) If an individual designated under the agency license commits an act or fails to  
4467 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
4468 the commissioner may suspend, revoke, or limit the license of:

4469 (i) the individual;

4470 (ii) the agency, if the agency:

4471 (A) is reckless or negligent in its supervision of the individual; or

4472 (B) knowingly participated in the act or failure to act that is the ground for suspending,  
4473 revoking, or limiting the license; or

4474 (iii) (A) the individual; and

4475 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

4476 (6) A licensee under this chapter is subject to the penalties for conducting an insurance  
4477 business without a license if:

4478 (a) the licensee's license is:

4479 (i) revoked;

4480 (ii) suspended;

4481 (iii) limited;

4482 (iv) surrendered in lieu of administrative action;

4483 (v) lapsed; or

4484 (vi) voluntarily surrendered; and

4485 (b) the licensee:

4486 (i) continues to act as a licensee; or

4487 (ii) violates the terms of the license limitation.

4488 (7) A licensee under this chapter shall immediately report to the commissioner:

4489 (a) a revocation, suspension, or limitation of the person's license in any other state, the

4490 District of Columbia, or a territory of the United States;

4491 (b) the imposition of a disciplinary sanction imposed on that person by any other state,  
4492 the District of Columbia, or a territory of the United States; or

4493 (c) a judgment or injunction entered against that person on the basis of conduct  
4494 involving:

4495 (i) fraud;

4496 (ii) deceit;

4497 (iii) misrepresentation; or

4498 (iv) a violation of an insurance law or rule.

4499 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a  
4500 license in lieu of administrative action may specify a time not to exceed five years within  
4501 which the former licensee may not apply for a new license.

4502 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the  
4503 former licensee may not apply for a new license for five years without the express approval of  
4504 the commissioner.

4505 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
4506 a license issued under this part if so ordered by a court.

4507 (10) The commissioner shall by rule prescribe the license renewal and reinstatement  
4508 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4509 Section 44. Section **31A-26-301.6** is amended to read:

4510 **31A-26-301.6. Health care claims practices.**

4511 (1) As used in this section:

4512 [~~(a) "Articulate reason" may include a determination regarding:~~]

4513 [~~(i) eligibility for coverage;~~]

4514 [~~(ii) preexisting conditions;~~]

4515 [~~(iii) applicability of other public or private insurance;~~]

4516 [~~(iv) medical necessity, and~~]

4517 [~~(v) any other reason that would justify an extension of the time to investigate a claim.]~~]

4518 [~~(b)~~] (a) "Health care provider" means a person licensed to provide health care under:

4519 (i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

4520 (ii) Title 58, Occupations and Professions.

4521           ~~[(e)]~~ (b) "Insurer" means an admitted or authorized insurer, as defined in Section  
4522 31A-1-301, and includes:

- 4523           (i) a health maintenance organization; and
- 4524           (ii) a third party administrator that is subject to this title, provided that nothing in this  
4525 section may be construed as requiring a third party administrator to use its own funds to pay  
4526 claims that have not been funded by the entity for which the third party administrator is paying  
4527 claims.

4528           ~~[(d)]~~ (c) "Provider" means a health care provider to whom an insurer is obligated to pay  
4529 directly in connection with a claim by virtue of:

- 4530           (i) an agreement between the insurer and the provider;
- 4531           (ii) a health insurance policy or contract of the insurer; or
- 4532           (iii) state or federal law.

4533           (2) An insurer shall timely pay every valid insurance claim submitted by a provider in  
4534 accordance with this section.

4535           (3) (a) Except as provided in Subsection (4), within 30 days of the day on which the  
4536 insurer receives a written claim, an insurer shall:

- 4537           (i) pay the claim; or
- 4538           (ii) deny the claim and provide a written explanation for the denial.

4539           (b) (i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a)  
4540 may be extended by 15 days if the insurer:

4541           (A) determines that the extension is necessary due to matters beyond the control of the  
4542 insurer; and

4543           (B) before the end of the 30-day period described in Subsection (3)(a), notifies the  
4544 provider and insured in writing of:

- 4545           (I) the circumstances requiring the extension of time; and
- 4546           (II) the date by which the insurer expects to pay the claim or deny the claim with a  
4547 written explanation for the denial.

4548           (ii) If an extension is necessary due to a failure of the provider or insured to submit the  
4549 information necessary to decide the claim:

4550           (A) the notice of extension required by this Subsection (3)(b) shall specifically describe  
4551 the required information; and

4552 (B) the insurer shall give the provider or insured at least 45 days from the day on which  
4553 the provider or insured receives the notice before the insurer denies the claim for failure to  
4554 provide the information requested in Subsection (3)(b)(ii)(A).

4555 (4) (a) In the case of a claim for income replacement benefits, within 45 days of the day  
4556 on which the insurer receives a written claim, an insurer shall:

4557 (i) pay the claim; or

4558 (ii) deny the claim and provide a written explanation of the denial.

4559 (b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a)  
4560 may be extended for 30 days if the insurer:

4561 (i) determines that the extension is necessary due to matters beyond the control of the  
4562 insurer; and

4563 (ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies  
4564 the insured of:

4565 (A) the circumstances requiring the extension of time; and

4566 (B) the date by which the insurer expects to pay the claim or deny the claim with a  
4567 written explanation for the denial.

4568 (c) Subject to Subsections (4)(d) and (e), the time period for complying with  
4569 Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the  
4570 30-day extension period provided in Subsection (4)(b) ends if before the day on which the  
4571 30-day extension period ends, the insurer:

4572 (i) determines that due to matters beyond the control of the insurer a decision cannot be  
4573 rendered within the 30-day extension period; and

4574 (ii) notifies the insured of:

4575 (A) the circumstances requiring the extension; and

4576 (B) the date as of which the insurer expects to pay the claim or deny the claim with a  
4577 written explanation for the denial.

4578 (d) A notice of extension under this Subsection (4) shall specifically explain:

4579 (i) the standards on which entitlement to a benefit is based; and

4580 (ii) the unresolved issues that prevent a decision on the claim.

4581 (e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of  
4582 the insured to submit the information necessary to decide the claim:

4583 (i) the notice of extension required by Subsection (4)(b) or (c) shall specifically  
4584 describe the necessary information; and

4585 (ii) the insurer shall give the insured at least 45 days from the day on which the insured  
4586 receives the notice before the insurer denies the claim for failure to provide the information  
4587 requested in Subsection (4)(b) or (c).

4588 (5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or  
4589 (4)(c), due to an insured or provider failing to submit information necessary to decide a claim,  
4590 the period for making the benefit determination shall be tolled from the date on which the  
4591 notification of the extension is sent to the insured or provider until the date on which the  
4592 insured or provider responds to the request for additional information.

4593 (6) An insurer shall pay all sums to the provider or insured that the insurer is obligated  
4594 to pay on the claim, and provide a written explanation of the insurer's decision regarding any  
4595 part of the claim that is denied within 20 days of receiving the information requested under  
4596 Subsection (3)(b), (4)(b), or (4)(c).

4597 (7) (a) Whenever an insurer makes a payment to a provider on any part of a claim  
4598 under this section, the insurer shall also send to the insured an explanation of benefits paid.

4599 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall  
4600 also send to the insured:

4601 (i) a written explanation of the part of the claim that was denied; and

4602 (ii) notice of the adverse benefit determination review process established under  
4603 Section [31A-22-629](#).

4604 (c) This Subsection (7) does not apply to a person receiving benefits under the state  
4605 Medicaid program as defined in Section [26-18-2](#), unless required by the Department of Health  
4606 or federal law.

4607 (8) (a) [~~Beginning with health care claims submitted on or after January 1, 2002, a~~] A  
4608 late fee shall be imposed on:

4609 (i) an insurer that fails to timely pay a claim in accordance with this section; and

4610 (ii) a provider that fails to timely provide information on a claim in accordance with  
4611 this section.

4612 (b) For the first 90 days that a claim payment or a provider response to a request for  
4613 information is late, the late fee shall be determined by multiplying together:

- 4614 (i) the total amount of the claim the insurer is obliged to pay;
- 4615 (ii) the total number of days the response or the payment is late; and
- 4616 (iii) .1%.
- 4617 (c) For a claim payment or a provider response to a request for information that is 91 or
- 4618 more days late, the late fee shall be determined by adding together:
- 4619 (i) the late fee for a 90-day period under Subsection (8)(b); and
- 4620 (ii) the following multiplied together:
- 4621 (A) the total amount of the claim the insurer is obliged to pay;
- 4622 (B) the total number of days the response or payment was late beyond the initial 90-day
- 4623 period; and
- 4624 (C) the rate of interest set in accordance with Section 15-1-1.
- 4625 (d) Any late fee paid or collected under this section shall be separately identified on the
- 4626 documentation used by the insurer to pay the claim.
- 4627 (e) For purposes of this Subsection (8), "late fee" does not include an amount that is
- 4628 less than \$1.
- 4629 (9) Each insurer shall establish a review process to resolve claims-related disputes
- 4630 between the insurer and providers.
- 4631 (10) An insurer or person representing an insurer may not engage in any unfair claim
- 4632 settlement practice with respect to a provider. Unfair claim settlement practices include:
- 4633 (a) knowingly misrepresenting a material fact or the contents of an insurance policy in
- 4634 connection with a claim;
- 4635 (b) failing to acknowledge and substantively respond within 15 days to any written
- 4636 communication from a provider relating to a pending claim;
- 4637 (c) denying or threatening to deny the payment of a claim for any reason that is not
- 4638 clearly described in the insured's policy;
- 4639 (d) failing to maintain a payment process sufficient to comply with this section;
- 4640 (e) failing to maintain claims documentation sufficient to demonstrate compliance with
- 4641 this section;
- 4642 (f) failing, upon request, to give to the provider written information regarding the
- 4643 specific rate and terms under which the provider will be paid for health care services;
- 4644 (g) failing to timely pay a valid claim in accordance with this section as a means of

4645 influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to  
4646 an unrelated claim, an undisputed part of a pending claim, or some other aspect of the  
4647 contractual relationship;

4648 (h) failing to pay the sum when required and as required under Subsection (8) when a  
4649 violation has occurred;

4650 (i) threatening to retaliate or actual retaliation against a provider for the provider  
4651 applying this section;

4652 (j) any material violation of this section; and

4653 (k) any other unfair claim settlement practice established in rule or law.

4654 (11) (a) The provisions of this section shall apply to each contract between an insurer  
4655 and a provider for the duration of the contract.

4656 (b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad  
4657 faith insurance claim.

4658 (c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer  
4659 and a provider from including provisions in their contract that are more stringent than the  
4660 provisions of this section.

4661 (12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, [~~and~~  
4662 ~~beginning January 1, 2002,~~] the commissioner may conduct examinations to determine an  
4663 insurer's level of compliance with this section and impose sanctions for each violation.

4664 (b) The commissioner may adopt rules only as necessary to implement this section.

4665 (c) The commissioner may establish rules to facilitate the exchange of electronic  
4666 confirmations when claims-related information has been received.

4667 (d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules  
4668 regarding the review process required by Subsection (9).

4669 (13) Nothing in this section may be construed as limiting the collection rights of a  
4670 provider under Section [31A-26-301.5](#).

4671 (14) Nothing in this section may be construed as limiting the ability of an insurer to:

4672 (a) recover any amount improperly paid to a provider or an insured:

4673 (i) in accordance with Section [31A-31-103](#) or any other provision of state or federal  
4674 law;

4675 (ii) within 24 months of the amount improperly paid for a coordination of benefits

4676 error;

4677 (iii) within 12 months of the amount improperly paid for any other reason not  
4678 identified in Subsection (14)(a)(i) or (ii); or

4679 (iv) within 36 months of the amount improperly paid when the improper payment was  
4680 due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any  
4681 other state or federal health care program;

4682 (b) take any action against a provider that is permitted under the terms of the provider  
4683 contract and not prohibited by this section;

4684 (c) report the provider to a state or federal agency with regulatory authority over the  
4685 provider for unprofessional, unlawful, or fraudulent conduct; or

4686 (d) enter into a mutual agreement with a provider to resolve alleged violations of this  
4687 section through mediation or binding arbitration.

4688 (15) A health care provider may only seek recovery from the insurer for an amount  
4689 improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b).

4690 (16) (a) (i) An insurer shall remit in full the payment the insurer is obligated to pay to  
4691 the health care provider or insured.

4692 (ii) The insurer's payment under this Subsection (16)(a) may not be reduced for fees  
4693 incurred for the method of payment, regardless of the payment method.

4694 (b) An insurer may offer the remittance of payment through a credit card or other  
4695 similar arrangement, if the health care provider or insured:

4696 (i) is not charged a fee; and

4697 (ii) voluntarily elects to receive remittance through a prepaid credit card or other  
4698 similar arrangement.

4699 (c) An insurer may not require a health care provider or insured to accept remittance  
4700 through a credit card or other similar arrangement.

4701 Section 45. Section **31A-27a-105** is amended to read:

4702 **31A-27a-105. Jurisdiction -- Venue.**

4703 (1) (a) A delinquency proceeding under this chapter may not be commenced by a  
4704 person other than the commissioner of this state.

4705 (b) No court has jurisdiction to entertain, hear, or determine a delinquency proceeding  
4706 commenced by any person other than the commissioner of this state.



4707 (2) Other than in accordance with this chapter, a court of this state has no jurisdiction  
4708 to entertain, hear, or determine any complaint:

4709 (a) requesting the liquidation, rehabilitation, seizure, sequestration, or receivership of  
4710 an insurer; or

4711 (b) requesting a stay, an injunction, a restraining order, or other relief preliminary to,  
4712 incidental to, or relating to a delinquency proceeding.

4713 (3) (a) The receivership court, as of the commencement of a delinquency proceeding  
4714 under this chapter, has exclusive jurisdiction of all property of the insurer, wherever located,  
4715 including property located outside the territorial limits of the state.

4716 (b) The receivership court has original but not exclusive jurisdiction of all civil  
4717 proceedings arising:

4718 (i) under this chapter; or

4719 (ii) in or related to a delinquency proceeding under this chapter.

4720 (4) In addition to other grounds for jurisdiction provided by the law of this state, a  
4721 court of this state having jurisdiction of the subject matter has jurisdiction over a person served  
4722 pursuant to the Utah Rules of Civil Procedure or other applicable provisions of law in an action  
4723 brought by the receiver if the person served:

4724 (a) in an action resulting from or incident to a relationship with the insurer described in  
4725 this Subsection (4)(a), is or has been an agent, broker, or other person who has at any time:

4726 (i) written a policy of insurance for an insurer against which a delinquency proceeding  
4727 is instituted; or

4728 (ii) acted in any manner whatsoever on behalf of an insurer against which a  
4729 delinquency proceeding is instituted;

4730 (b) in an action on or incident to a reinsurance contract described in this Subsection  
4731 (4)(b):

4732 (i) is or has been an insurer or reinsurer who has at any time entered into the contract of  
4733 reinsurance with an insurer against which a delinquency proceeding is instituted; or

4734 (ii) is an intermediary, agent, or broker of or for the reinsurer, or with respect to the  
4735 contract;

4736 (c) in an action resulting from or incident to a relationship with the insurer described in  
4737 this Subsection (4)(c), is or has been an officer, director, manager, trustee, organizer, promoter,

4738 or other person in a position of comparable authority or influence over an insurer against which  
4739 a delinquency proceeding is instituted;

4740 (d) in an action concerning assets described in this Subsection (4)(d), is or was at the  
4741 time of the institution of the delinquency proceeding against the insurer, holding assets in  
4742 which the receiver claims an interest on behalf of the insurer; or

4743 (e) in any action on or incident to the obligation described in this Subsection (4)(e), is  
4744 obligated to the insurer in any way whatsoever.

4745 (5) (a) Subject to Subsection (5)(b), service shall be made upon the person named in  
4746 the petition in accordance with the Utah Rules of Civil Procedure.

4747 (b) In lieu of service under Subsection (5)(a), upon application to the receivership  
4748 court, service may be made in such a manner as the receivership court directs whenever it is  
4749 satisfactorily shown by the commissioner's affidavit:

4750 (i) in the case of a corporation, that the officers of the corporation cannot be served  
4751 because they have departed from the state or have otherwise concealed themselves with intent  
4752 to avoid service;

4753 (ii) in the case of an insurer whose business is conducted, at least in part, by an  
4754 attorney-in-fact, managing general agent, or other similar entity including a reciprocal, Lloyd's  
4755 association, or interinsurance exchange, that the individual attorney-in-fact, managing general  
4756 agent, or other entity, or its officers of the corporate attorney-in-fact cannot be served because  
4757 of the individual's departure or concealment; or

4758 (iii) in the case of a natural person, that the person cannot be served because of the  
4759 person's departure or concealment.

4760 (6) If the receivership court on motion of any party finds that an action should as a  
4761 matter of substantial justice be tried in a forum outside this state, the receivership court may  
4762 enter an appropriate order to stay further proceedings on the action in this state.

4763 (7) (a) Nothing in this chapter deprives a reinsurer of any contractual right to pursue  
4764 arbitration except:

4765 (i) as to a claim against the estate; and

4766 (ii) in regard to a contract rejected by the receiver under Section [31A-27a-113](#).

4767 (b) A party in arbitration may bring a claim or counterclaim against the estate, but the  
4768 claim or counterclaim is subject to this chapter.

4769 (8) An action authorized by this chapter shall be brought in the Third District Court for  
4770 Salt Lake County.

4771 (9) (a) At any time after an order is entered pursuant to Section 31A-27a-201,  
4772 31A-27a-301, or 31A-27a-401, the commissioner or receiver may transfer the case to the  
4773 county of the principal office of the person proceeded against.

4774 (b) In the event of a transfer under this Subsection (9), the court in which the  
4775 proceeding is commenced shall, upon application of the commissioner or receiver, direct its  
4776 clerk to transmit the court's file to the clerk of the court to which the case is to be transferred.

4777 (c) After a transfer under this Subsection (9), the proceeding shall be conducted in the  
4778 same manner as if it had been commenced in the court to which the matter is transferred.

4779 (10) (a) Except as provided in Subsection (10)(c), a person may not intervene in a  
4780 liquidation proceeding in this state for the purpose of seeking or obtaining payment of a  
4781 judgment, lien, or other claim of any kind.

4782 (b) Except as provided in Subsection (10)(c), the claims procedure set for this chapter  
4783 constitute the exclusive means for obtaining payment of claims from the liquidation estate.

4784 (c) (i) An affected guaranty association or the affected guaranty association's  
4785 representative may intervene as a party as a matter of right and otherwise appear and participate  
4786 in any court proceeding concerning a liquidation proceeding against an insurer.

4787 (ii) Intervention by an affected guaranty association or by an affected guaranty  
4788 association's designated representative conferred by this Subsection (10)(c) may not constitute  
4789 grounds to establish general personal jurisdiction by the courts of this state.

4790 (iii) An intervening affected guaranty association or the affected guaranty association's  
4791 representative are subject to the receivership court's jurisdiction for the limited purpose for  
4792 which the affected guaranty association intervenes.

4793 (11) (a) Notwithstanding the other provisions of this section, this chapter does not  
4794 confer jurisdiction on the receivership court to resolve coverage disputes between an affected  
4795 guaranty association and those asserting claims against the affected guaranty association  
4796 resulting from the initiation of a receivership proceeding under this chapter, except to the  
4797 extent that the affected guaranty association otherwise expressly consents to the jurisdiction of  
4798 the receivership court pursuant to a plan of rehabilitation or liquidation that resolves its  
4799 obligations to covered policyholders.

4800 (b) The determination of a dispute with respect to the statutory coverage obligations of  
4801 an affected guaranty association by a court or administrative agency or body with jurisdiction  
4802 in the affected guaranty association's state of domicile is binding and conclusive as to the  
4803 affected guaranty association's claim in the liquidation proceeding.

4804 (12) Upon the request of the receiver, the receivership court or the presiding judge of  
4805 the Third District Court for Salt Lake County may order that one judge hear all cases and  
4806 controversies arising out of or related to the delinquency proceeding.

4807 (13) A delinquency proceeding is exempt from any program maintained for the early  
4808 closure of civil actions.

4809 (14) In a proceeding, case, or controversy arising out of or related to a delinquency  
4810 proceeding, to the extent there is a conflict between the Utah Rules of Civil Procedure and this  
4811 chapter, the provisions of this chapter govern the proceeding, case, or controversy.

4812 Section 46. Section **31A-27a-501** is amended to read:

4813 **31A-27a-501. Turnover of assets.**

4814 (1) (a) If the receiver determines that funds or property in the possession of another  
4815 person are rightfully the property of the estate, the receiver shall deliver to the person a written  
4816 demand for immediate delivery of the funds or property:

4817 (i) referencing this section by number;

4818 (ii) referencing the court and docket number of the receivership action; and

4819 (iii) notifying the person that any claim of right to the funds or property by the person  
4820 shall be presented to the receivership court within 20 days of the day on which the person  
4821 receives the written demand.

4822 (b) (i) A person who holds funds or other property belonging to an entity subject to an  
4823 order of receivership under this chapter shall deliver the funds or other property to the receiver  
4824 on demand.

4825 (ii) If the person described in Subsection (1)(b)(i) alleges a right to retain the funds or  
4826 other property, the person shall:

4827 (A) file [~~a pleading~~] an objection with the receivership court setting out that right  
4828 within 20 days of the day on which the person receives the demand that the funds or property  
4829 be delivered to the receiver; and

4830 (B) serve a copy of the [~~pleading~~] objection on the receiver.

4831 (iii) The [~~pleading~~] objection described in Subsection (1)(b)(ii) shall inform the  
4832 receivership court as to:

4833 (A) the nature of the claim to the funds or property;

4834 (B) the alleged value of the property or amount of funds held; and

4835 (C) what action has been taken by the person to preserve any funds or to preserve and  
4836 protect the property pending determination of the dispute.

4837 (c) The relinquishment of possession of funds or property by a person who receives a  
4838 demand pursuant to this section is not a waiver of a right to make a claim in the receivership.

4839 (2) (a) If requested by the receiver, the receivership court shall hold a hearing to  
4840 determine where and under what conditions the funds or property shall be held by a person  
4841 described in Subsection (1) pending determination of a dispute concerning the funds or  
4842 property.

4843 (b) The receivership court may impose the conditions the receivership court considers  
4844 necessary or appropriate for the preservation of the funds or property until the receivership  
4845 court can determine the validity of the person's claim to the funds or property.

4846 (c) If funds or property are allowed to remain in the possession of the person after  
4847 demand made by the receiver, that person is strictly liable to the estate for any waste, loss, or  
4848 damage to or diminution of value of the funds or property retained.

4849 (3) If a person files [~~a pleading~~] an objection alleging a right to retain funds or property  
4850 as provided in Subsection (1), the receivership court shall hold a subsequent hearing to  
4851 determine the entitlement of the person to the funds or property claimed by the receiver.

4852 (4) If a person fails to deliver the funds or property or to file the [~~pleading~~] objection  
4853 described by Subsection (1) within the 20-day period, the receivership court may issue a  
4854 summary order:

4855 (a) upon:

4856 (i) petition of the receiver; and

4857 (ii) a copy of the petition being served by the petitioner to that person;

4858 (b) directing the immediate delivery of the funds or property to the receiver; and

4859 (c) finding that the person waived all claims of right to the funds or property.

4860 (5) The liquidator shall reduce the assets to a degree of liquidity that is consistent with  
4861 the effective execution of the liquidation.

4862 Section 47. Section 31A-30-117 is amended to read:

4863 **31A-30-117. Patient Protection and Affordable Care Act -- Market transition.**

4864 (1) (a) [~~After complying with the reporting requirements of Section 63N-11-106, the~~

4865 The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3,

4866 Utah Administrative Rulemaking Act, that change the rating and underwriting requirements of

4867 this chapter as necessary to transition the insurance market to meet federal qualified health plan

4868 standards and rating practices under PPACA.

4869 (b) Administrative rules adopted by the commissioner under this section may include:

4870 (i) the regulation of health benefit plans as described in [~~Subsections 31A-2-212(5)(a)~~

4871 ~~and (b)] Subsection 31A-2-212(5); and~~

4872 (ii) disclosure of records and information required by PPACA and state law.

4873 (c) (i) The commissioner shall establish by administrative rule one statewide open

4874 enrollment period that applies to the individual insurance market that is not on the PPACA

4875 certified individual exchange.

4876 (ii) The statewide open enrollment period:

4877 (A) may be shorter, but no longer than the open enrollment period established for the

4878 individual insurance market offered in the PPACA certified exchange; and

4879 (B) may not be extended beyond the dates of the open enrollment period established

4880 for the individual insurance market offered in the PPACA certified exchange.

4881 (2) A carrier that offers health benefit plans in the individual market that is not part of

4882 the individual PPACA certified exchange:

4883 (a) shall open enrollment:

4884 (i) during the statewide open enrollment period established in Subsection (1)(c); and

4885 (ii) at other times, for qualifying events, as determined by administrative rule adopted

4886 by the commissioner; and

4887 (b) may open enrollment at any time.

4888 (3) To the extent permitted by the Centers for Medicare and Medicaid Services policy,

4889 or federal regulation, the commissioner shall allow a health insurer to choose to continue

4890 coverage and individuals and small employers to choose to re-enroll in coverage in

4891 nongrandfathered health coverage that is not in compliance with market reforms required by

4892 PPACA.

4893 Section 48. Section 31A-30-118 is amended to read:

4894 **31A-30-118. Patient Protection and Affordable Care Act -- State insurance**  
4895 **mandates -- Cost of additional benefits.**

4896 (1) (a) The commissioner shall identify a new mandated benefit that is in excess of the  
4897 essential health benefits required by PPACA.

4898 (b) The state shall quantify the cost attributable to each additional mandated benefit  
4899 specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost  
4900 associated with the mandated benefit, which shall be:

4901 (i) calculated in accordance with generally accepted actuarial principles and  
4902 methodologies;

4903 (ii) conducted by a member of the American Academy of Actuaries; and

4904 (iii) reported to the commissioner and to the individual exchange operating in the state.

4905 (c) The commissioner may require a proponent of a new mandated benefit under  
4906 Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance  
4907 with Subsection (1)(b). The commissioner may use the cost information provided under this  
4908 Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).

4909 (2) If the state is required to defray the cost of additional required benefits under the  
4910 provisions of 45 C.F.R. 155.170:

4911 (a) the state shall make the required payments:

4912 (i) in accordance with Subsection (3); and

4913 (ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;

4914 (b) an issuer of a qualified health plan that receives a payment under the provisions of  
4915 Subsection (1) and 45 C.F.R. 155.170 shall:

4916 (i) reduce the premium charged to the individual on whose behalf the issuer will be  
4917 paid under Subsection (1), in an amount equal to the amount of the payment under Subsection  
4918 (1); or

4919 (ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an  
4920 individual on whose behalf the issuer received a payment under Subsection (1), in an amount  
4921 equal to the amount of the payment under Subsection (1); and

4922 (c) a premium rebate made under this section is not a prohibited inducement under  
4923 Section 31A-23a-402.5.

4924 (3) A payment required under 45 C.F.R. 155.170(c) shall:

4925 (a) unless otherwise required by PPACA, be based on a statewide average of the cost  
4926 of the additional benefit for all issuers who are entitled to payment under the provisions of 45  
4927 C.F.R. [~~155.70~~] 155.170; and

4928 (b) be submitted to an issuer through a process established [~~and administered by the~~  
4929 ~~federal marketplace exchange for the state under PPACA for individual health plans~~] by the  
4930 commissioner.

4931 (4) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah  
4932 Administrative Rulemaking Act, to:

4933 (a) [~~adopt rules as necessary to~~] administer the provisions of this section and 45 C.F.R.  
4934 155.170; and

4935 (b) establish or implement a process for submitting a payment to an issuer under  
4936 Subsection (3)(b).

4937 Section 49. Section ~~31A-35-402~~ is amended to read:

4938 **31A-35-402. Authority related to bail bonds.**

4939 (1) A bail bond agency may only sell bail bonds.

4940 (2) In accordance with Section ~~31A-23a-205~~, a bail bond producer may not execute or  
4941 issue a bail bond in this state without holding a current appointment from a surety insurer or a  
4942 current designation from a bail bond agency.

4943 (3) A bail bond [~~surety~~] agency or surety insurer may not allow any person who is not a  
4944 bail bond producer to engage in the bail bond insurance business on the bail bond agency's or  
4945 surety insurer's behalf, except for individuals:

4946 (a) employed solely for the performance of clerical, stenographic, investigative, or  
4947 other administrative duties that do not require a license as:

4948 (i) a bail bond agency; or

4949 (ii) a bail bond producer; and

4950 (b) whose compensation is not related to or contingent upon the number of bail bonds  
4951 written.

4952 Section 50. Section ~~31A-37-303~~ is amended to read:

4953 **31A-37-303. Reinsurance.**

4954 (1) (a) A captive insurance company may cede risks to any insurance company



4955 approved by the commissioner.

4956 (b) A captive insurance company may provide reinsurance, as authorized in this title,  
4957 on risks ceded [~~for the benefit of a parent, affiliate, or controlled unaffiliated business~~] by any  
4958 other insurer with prior approval of the commissioner.

4959 (2) (a) A captive insurance company may take credit for reserves on risks or portions of  
4960 risks ceded to reinsurers if the captive insurance company complies with Section 31A-17-404,  
4961 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or if the captive insurance company complies  
4962 with other requirements as the commissioner may establish by rule made in accordance with  
4963 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4964 (b) Unless the reinsurer is in compliance with Section 31A-17-404, 31A-17-404.1,  
4965 31A-17-404.3, or 31A-17-404.4 or a rule adopted under Subsection (2)(a), a captive insurance  
4966 company may not take credit for:

- 4967 (i) reserves on risks ceded to a reinsurer; or  
4968 (ii) portions of risks ceded to a reinsurer.

4969 Section 51. Section 31A-37-701 is amended to read:

4970 **31A-37-701. Certificate of dormancy.**

4971 (1) In accordance with the provisions of this section, a captive insurance company,  
4972 other than a risk retention group may apply, without fee, to the commissioner for a certificate  
4973 of dormancy.

4974 (2) (a) A captive insurance company, other than a risk retention group, is eligible for a  
4975 certificate of dormancy if the captive insurance company:

4976 (i) has ceased transacting the business of insurance, including the issuance of insurance  
4977 policies; and

4978 (ii) has no remaining insurance liabilities or obligations associated with insurance  
4979 business transactions or insurance policies.

4980 (b) For purposes of Subsection (2)(a)(ii), the commissioner may disregard liabilities or  
4981 obligations for which the captive insurance company has withheld sufficient funds or that are  
4982 otherwise sufficiently secured.

4983 (3) Except as provided in Subsection (5), a captive insurance company that holds a  
4984 certificate of dormancy is subject to all requirements of this chapter.

4985 (4) A captive insurance company that holds a certificate of dormancy:

4986 (a) shall possess and maintain unimpaired paid-in capital and unimpaired paid-in  
4987 surplus of:

4988 (i) in the case of a pure captive insurance company or a special purpose captive  
4989 insurance company, not less than \$25,000;

4990 (ii) in the case of an association captive insurance company, not less than \$75,000; or

4991 (iii) in the case of a sponsored captive insurance company, not less than \$100,000, of  
4992 which at least \$35,000 is provided by the sponsor; and

4993 (b) is not required to:

4994 (i) subject to Subsection (5), submit an annual audit or statement of actuarial opinion;

4995 (ii) maintain an active agreement with an independent auditor or actuary; or

4996 (iii) hold an annual meeting of the captive insurance company in the state.

4997 (5) The commissioner may require a captive insurance company that holds a certificate  
4998 of dormancy to submit an annual audit if the commissioner determines that there are concerns  
4999 regarding the captive insurance company's solvency or liquidity.

5000 (6) To maintain a certificate of dormancy and in lieu of a certificate of authority  
5001 renewal fee, no later than July 1 of each year, a captive insurance company shall pay an annual  
5002 dormancy renewal fee that is equal to 50% of the captive insurance's company's certificate of  
5003 authority renewal fee.

5004 (7) A captive insurance company may consecutively renew a certificate [or] of  
5005 dormancy no more than five times.

5006 Section 52. Section **34A-2-202** is amended to read:

5007 **34A-2-202. Assessment on self-insured employers including the state, counties,**  
5008 **cities, towns, or school districts paying compensation direct.**

5009 (1) (a) (i) A self-insured employer, including a county, city, town, or school district,  
5010 shall pay annually, on or before March 31, an assessment in accordance with this section and  
5011 rules made by the commission under this section.

5012 (ii) For purposes of this section, "self-insured employer" is as defined in Section  
5013 **34A-2-201.5**, except it includes the state if the state self-insures under Section **34A-2-203**.

5014 (b) The assessment required by Subsection (1)(a) is:

5015 (i) to be collected by the State Tax Commission;

5016 (ii) paid by the State Tax Commission into the state treasury as provided in Subsection

5017 59-9-101(2); and

5018 (iii) subject to the offset provided in Section 34A-2-202.5.

5019 (c) The assessment under Subsection (1)(a) shall be based on a total calculated  
5020 premium multiplied by the premium assessment rate established pursuant to Subsection

5021 59-9-101(2).

5022 (d) The total calculated premium, for purposes of calculating the assessment under  
5023 Subsection (1)(a), shall be calculated by:

5024 (i) multiplying the total of the standard premium for each class code calculated in  
5025 Subsection (1)(e) by the self-insured employer's experience modification factor; and

5026 (ii) multiplying the total under Subsection (1)(d)(i) by a safety factor determined under  
5027 Subsection (1)(g).

5028 (e) A standard premium shall be calculated by:

5029 (i) multiplying the [prospective] advisory loss cost for the year being considered, as  
5030 filed with the insurance department pursuant to Section 31A-19a-406, for each applicable class  
5031 code by 1.10 to determine the manual rate for each class code; and

5032 (ii) multiplying the manual rate for each class code under Subsection (1)(e)(i) by each  
5033 \$100 of the self-insured employer's covered payroll for each class code.

5034 (f) (i) Each self-insured employer paying compensation direct shall annually obtain the  
5035 experience modification factor required in Subsection (1)(d)(i) by using:

5036 (A) the rate service organization designated by the insurance commissioner in Section  
5037 31A-19a-404; or

5038 (B) for a self-insured employer that is a public agency insurance mutual, an actuary  
5039 approved by the commission.

5040 (ii) If a self-insured employer's experience modification factor under Subsection  
5041 (1)(f)(i) is less than 0.50, the self-insured employer shall use an experience modification factor  
5042 of 0.50 in determining the total calculated premium.

5043 (g) To provide incentive for improved safety, the safety factor required in Subsection  
5044 (1)(d)(ii) shall be determined based on the self-insured employer's experience modification  
5045 factor as follows:

|      |                     |               |
|------|---------------------|---------------|
|      | EXPERIENCE          |               |
| 5046 | MODIFICATION FACTOR | SAFETY FACTOR |

|      |  |      |
|------|--|------|
| 5047 | Less than or equal to 0.90                       | 0.56 |
| 5048 | Greater than 0.90 but less than or equal to 1.00 | 0.78 |
| 5049 | Greater than 1.00 but less than or equal to 1.10 | 1.00 |
| 5050 | Greater than 1.10 but less than or equal to 1.20 | 1.22 |
| 5051 | Greater than 1.20                                | 1.44 |

5052 (h) (i) A premium or premium assessment modification other than a premium or  
5053 premium assessment modification under this section may not be allowed.

5054 (ii) If a self-insured employer paying compensation direct fails to obtain an experience  
5055 modification factor as required in Subsection (1)(f)(i) within the reasonable time period  
5056 established by rule by the State Tax Commission, the State Tax Commission shall use an  
5057 experience modification factor of 2.00 and a safety factor of 2.00 to calculate the total  
5058 calculated premium for purposes of determining the assessment.

5059 (iii) ~~Prior to~~ Before calculating the total calculated premium under Subsection  
5060 (1)(h)(ii), the State Tax Commission shall provide the self-insured employer with written  
5061 notice that failure to obtain an experience modification factor within a reasonable time period,  
5062 as established by rule by the State Tax Commission:

5063 (A) shall result in the State Tax Commission using an experience modification factor  
5064 of 2.00 and a safety factor of 2.00 in calculating the total calculated premium for purposes of  
5065 determining the assessment; and

5066 (B) may result in the division revoking the self-insured employer's right to pay  
5067 compensation direct.

5068 (i) The division may immediately revoke a self-insured employer's certificate issued  
5069 under Sections [34A-2-201](#) and [34A-2-201.5](#) that permits the self-insured employer to pay  
5070 compensation direct if the State Tax Commission assigns an experience modification factor  
5071 and a safety factor under Subsection (1)(h) because the self-insured employer failed to obtain  
5072 an experience modification factor.

5073 (2) Notwithstanding the annual payment requirement in Subsection (1)(a), a  
5074 self-insured employer whose total assessment obligation under Subsection (1)(a) for the  
5075 preceding year was \$10,000 or more shall pay the assessment in quarterly installments in the  
5076 same manner provided in Section [59-9-104](#) and subject to the same penalty provided in Section

5077 [59-9-104](#) for not paying or underpaying an installment.

5078 (3) (a) The State Tax Commission shall have access to all the records of the division  
5079 for the purpose of auditing and collecting any amounts described in this section.

5080 (b) Time periods for the State Tax Commission to allow a refund or make an  
5081 assessment shall be determined in accordance with Title 59, Chapter 1, Part 14, Assessment,  
5082 Collections, and Refunds Act.

5083 (4) (a) A review of appropriate use of job class assignment and calculation  
5084 methodology may be conducted as directed by the division at any reasonable time as a  
5085 condition of the self-insured employer's certification of paying compensation direct.

5086 (b) The State Tax Commission shall make any records necessary for the review  
5087 available to the commission.

5088 (c) The commission shall make the results of any review available to the State Tax  
5089 Commission.

5090 Section 53. Section **63A-5-205.5** is amended to read:

5091 **63A-5-205.5. Health insurance requirements -- Penalties.**

5092 (1) As used in this section:

5093 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
5094 related to a single project.

5095 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

5096 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
5097 "operative" who:

5098 (i) works at least 30 hours per calendar week; and

5099 (ii) meets employer eligibility waiting requirements for health care insurance, which  
5100 may not exceed the first day of the calendar month following 60 days after the day on which  
5101 the individual is hired.

5102 (d) "Health benefit plan" means:

5103 (i) the same as that term is defined in Section [31A-1-301](#)~~[-];~~ or

5104 (ii) an employee welfare benefit plan:

5105 (A) established under the Employee Retirement Income Security Act of 1974, 29

5106 U.S.C. Sec. 1001 et seq.;

5107 (B) for an employer with 100 or more employees; and

5108 (C) in which the employer establishes a self-funded or partially self-funded group  
5109 health plan to provide medical care for the employer's employees and dependents of the  
5110 employees.

5111 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in  
5112 Section 26-40-115.

5113 (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

5114 (g) "Third party administrator" or "administrator" means the same as that term is  
5115 defined in Section 31A-1-301.

5116 (2) Except as provided in Subsection (3), the requirements of this section apply to:

5117 (a) a contractor of a design or construction contract entered into by the division or the  
5118 State Building Board on or after July 1, 2009, if the prime contract is in an aggregate amount  
5119 equal to or greater than \$2,000,000; and

5120 (b) a subcontractor of a contractor of a design or construction contract entered into by  
5121 the division or State Building Board on or after July 1, 2009, if the subcontract is in an  
5122 aggregate amount equal to or greater than \$1,000,000.

5123 (3) The requirements of this section do not apply to a contractor or subcontractor  
5124 described in Subsection (2) if:

5125 (a) the application of this section jeopardizes the receipt of federal funds;

5126 (b) the contract is a sole source contract; or

5127 (c) the contract is an emergency procurement.

5128 (4) A person that intentionally uses change orders, contract modifications, or multiple  
5129 contracts to circumvent the requirements of this section is guilty of an infraction.

5130 (5) (a) A contractor that is subject to the requirements of this section shall demonstrate  
5131 to the director that the contractor has and will maintain an offer of qualified health [~~insurance~~]  
5132 coverage for the contractor's employees and the employees' dependents by submitting to the  
5133 director a written statement that:

5134 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with  
5135 Section 26-40-115;

5136 (ii) is from:

5137 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

5138 (B) an underwriter who is responsible for developing the employer group's premium

5139 rates; ~~[and]~~ or

5140 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),

5141 an actuary or underwriter selected by a third party administrator; and

5142 (iii) was created within one year before the day on which the statement is submitted.

5143 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)

5144 shall provide the actuary or underwriter selected by an administrator, as described in

5145 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's

5146 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the

5147 requirements of qualified health coverage.

5148 (ii) A contractor may not make a change to the contractor's contribution to the health

5149 benefit plan, unless the contractor provides notice to:

5150 (A) the actuary or underwriter selected by an administrator, as described in Subsection

5151 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in

5152 Subsection (5)(a) in compliance with this section; and

5153 (B) the division.

5154 ~~[(b)]~~ (c) A contractor that is subject to the requirements of this section shall:

5155 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that

5156 is subject to the requirements of this section shall obtain and maintain an offer of qualified

5157 health ~~[insurance]~~ coverage for the subcontractor's employees and the employees' dependents

5158 during the duration of the subcontract; and

5159 (ii) obtain from a subcontractor that is subject to the requirements of this section a

5160 written statement that:

5161 (A) the subcontractor offers qualified health ~~[insurance]~~ coverage that complies with

5162 Section [26-40-115](#);

5163 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, ~~[or]~~

5164 an underwriter who is responsible for developing the employer group's premium rates, or if the

5165 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or

5166 underwriter selected by an administrator; and

5167 (C) was created within one year before the day on which the contractor obtains the

5168 statement.

5169 ~~[(e)]~~ (d) (i) (A) A contractor that fails to maintain an offer of qualified health

5170 [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is  
5171 subject to penalties in accordance with administrative rules adopted by the division under  
5172 Subsection (6).

5173 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
5174 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection  
5175 (5)[~~(b)~~](c)(i).

5176 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
5177 [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i) during the duration of the  
5178 subcontract is subject to penalties in accordance with administrative rules adopted by the  
5179 division under Subsection (6).

5180 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
5181 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

5182 (6) The division shall adopt administrative rules:

5183 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

5184 (b) in coordination with:

5185 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

5186 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

5187 (iii) a public transit district in accordance with Section [17B-2a-818.5](#);

5188 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);

5189 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and

5190 (vi) the Legislature's Administrative Rules Review Committee; and

5191 (c) that establish:

5192 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
5193 demonstrate compliance with this section, including:

5194 (A) that a contractor or subcontractor's compliance with this section is subject to an  
5195 audit by the division or the Office of the Legislative Auditor General;

5196 (B) that a contractor that is subject to the requirements of this section shall obtain a  
5197 written statement described in Subsection (5)(a); and

5198 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
5199 written statement described in Subsection (5)[~~(b)~~](c)(ii);

5200 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally



5201 violates the provisions of this section, which may include:

5202 (A) a three-month suspension of the contractor or subcontractor from entering into  
5203 future contracts with the state upon the first violation;

5204 (B) a six-month suspension of the contractor or subcontractor from entering into future  
5205 contracts with the state upon the second violation;

5206 (C) an action for debarment of the contractor or subcontractor in accordance with  
5207 Section 63G-6a-904 upon the third or subsequent violation; and

5208 (D) monetary penalties which may not exceed 50% of the amount necessary to  
5209 purchase qualified health [insurance] coverage for employees and dependents of employees of  
5210 the contractor or subcontractor who were not offered qualified health [insurance] coverage  
5211 during the duration of the contract; and

5212 (iii) a website on which the department shall post the commercially equivalent  
5213 benchmark for the qualified health [insurance] coverage that is provided by the Department of  
5214 Health in accordance with Subsection 26-40-115(2).

5215 (7) (a) During the duration of a contract, the division may perform an audit to verify a  
5216 contractor or subcontractor's compliance with this section.

5217 (b) Upon the division's request, a contractor or subcontractor shall provide the division:

5218 (i) a signed actuarial certification that the coverage the contractor or subcontractor  
5219 offers is qualified health [insurance] coverage; or

5220 (ii) all relevant documents and information necessary for the division to determine  
5221 compliance with this section.

5222 (c) If a contractor or subcontractor provides the documents and information described  
5223 in Subsection (7)(b)(ii), the Insurance Department shall assist the division in determining if the  
5224 coverage the contractor or subcontractor offers is qualified health [insurance] coverage.

5225 (8) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
5226 or subcontractor that intentionally violates the provisions of this section is liable to the  
5227 employee for health care costs that would have been covered by qualified health [insurance]  
5228 coverage.

5229 (ii) An employer has an affirmative defense to a cause of action under Subsection  
5230 (8)(a) if:

5231 (A) the employer relied in good faith on a written statement described in Subsection

5232 (5)(a) or (5)(~~b~~)(c)(ii); or

5233 (B) the department determines that compliance with this section is not required under  
5234 the provisions of Subsection (3).

5235 (b) An employee has a private right of action only against the employee's employer to  
5236 enforce the provisions of this Subsection (8).

5237 (9) Any penalties imposed and collected under this section shall be deposited into the  
5238 Medicaid Restricted Account created by Section 26-18-402.

5239 (10) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~]  
5240 coverage as required by this section:

5241 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
5242 or contractor under:

5243 (i) Section 63G-6a-1602; or

5244 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

5245 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
5246 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
5247 or construction.

5248 (11) An administrator, including an administrator's actuary or underwriter, who  
5249 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
5250 coverage of a contractor or subcontractor who provides a health benefit plan described in  
5251 Subsection (1)(d)(ii):

5252 (a) subject to Subsection (11)(b), is not liable for an error in the written statement,  
5253 unless the administrator commits gross negligence in preparing the written statement;

5254 (b) is not liable for any error in the written statement if the administrator relied in good  
5255 faith on information from the contractor or subcontractor; and

5256 (c) may require as a condition of providing the written statement that a contractor or  
5257 subcontractor hold the administrator harmless for an action arising under this section.

5258 Section 54. Section 63C-9-403 is amended to read:

5259 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**

5260 (1) As used in this section:

5261 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
5262 related to a single project.

- 5263 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).
- 5264 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
5265 "operative" who:
- 5266 (i) works at least 30 hours per calendar week; and
- 5267 (ii) meets employer eligibility waiting requirements for health care insurance, which  
5268 may not exceed the first of the calendar month following 60 days after the day on which the  
5269 individual is hired.
- 5270 (d) "Health benefit plan" means:
- 5271 (i) the same as that term is defined in Section [31A-1-301](#)~~[-]~~; or
- 5272 (ii) an employee welfare benefit plan:
- 5273 (A) established under the Employee Retirement Income Security Act of 1974, 29  
5274 U.S.C. Sec. 1001 et seq.;
- 5275 (B) for an employer with 100 or more employees; and
- 5276 (C) in which the employer establishes a self-funded or partially self-funded group  
5277 health plan to provide medical care for the employer's employees and dependents of the  
5278 employees.
- 5279 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in  
5280 Section [26-40-115](#).
- 5281 (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).
- 5282 (g) "Third party administrator" or "administrator" means the same as that term is  
5283 defined in Section [31A-1-301](#).
- 5284 (2) Except as provided in Subsection (3), the requirements of this section apply to:
- 5285 (a) a contractor of a design or construction contract entered into by the board, or on  
5286 behalf of the board, on or after July 1, 2009, if the prime contract is in an aggregate amount  
5287 equal to or greater than \$2,000,000; and
- 5288 (b) a subcontractor of a contractor of a design or construction contract entered into by  
5289 the board, or on behalf of the board, on or after July 1, 2009, if the subcontract is in an  
5290 aggregate amount equal to or greater than \$1,000,000.
- 5291 (3) The requirements of this section do not apply to a contractor or subcontractor  
5292 described in Subsection (2) if:
- 5293 (a) the application of this section jeopardizes the receipt of federal funds;

5294 (b) the contract is a sole source contract; or  
5295 (c) the contract is an emergency procurement.  
5296 (4) A person that intentionally uses change orders, contract modifications, or multiple  
5297 contracts to circumvent the requirements of this section is guilty of an infraction.  
5298 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the  
5299 executive director that the contractor has and will maintain an offer of qualified health  
5300 [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the  
5301 duration of the contract by submitting to the executive director a written statement that:  
5302 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with  
5303 Section [26-40-115](#);  
5304 (ii) is from:  
5305 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]  
5306 (B) an underwriter who is responsible for developing the employer group's premium  
5307 rates; [~~and~~] or  
5308 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
5309 an actuary or underwriter selected by a third party administrator; and  
5310 (iii) was created within one year before the day on which the statement is submitted.  
5311 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)  
5312 shall provide the actuary or underwriter selected by the administrator, as described in  
5313 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
5314 contribution to the health benefit plan and the health benefit plan's actuarial value meets the  
5315 requirements of qualified health coverage.  
5316 (ii) A contractor may not make a change to the contractor's contribution to the health  
5317 benefit plan, unless the contractor provides notice to:  
5318 (A) the actuary or underwriter selected by the administrator, as described in Subsection  
5319 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
5320 Subsection (5)(a) in compliance with this section; and  
5321 (B) the executive director.  
5322 [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:  
5323 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that  
5324 is subject to the requirements of this section shall obtain and maintain an offer of qualified

5325 health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents  
5326 during the duration of the subcontract; and

5327 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
5328 written statement that:

5329 (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with  
5330 Section [26-40-115](#);

5331 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~]  
5332 an underwriter who is responsible for developing the employer group's premium rates, or if the  
5333 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or  
5334 underwriter selected by an administrator; and

5335 (C) was created within one year before the day on which the contractor obtains the  
5336 statement.

5337 [~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health  
5338 [~~insurance~~] coverage as described in Subsection (5)(a) during the duration of the contract is  
5339 subject to penalties in accordance with administrative rules adopted by the division under  
5340 Subsection (6).

5341 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
5342 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection  
5343 (5)[~~(b)~~](c)(i).

5344 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
5345 [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i) during the duration of the  
5346 subcontract is subject to penalties in accordance with administrative rules adopted by the  
5347 department under Subsection (6).

5348 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
5349 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

5350 (6) The department shall adopt administrative rules:

5351 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

5352 (b) in coordination with:

5353 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

5354 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

5355 (iii) the State Building Board in accordance with Section [63A-5-205.5](#);

5356 (iv) a public transit district in accordance with Section 17B-2a-818.5;

5357 (v) the Department of Transportation in accordance with Section 72-6-107.5; and

5358 (vi) the Legislature's Administrative Rules Review Committee; and

5359 (c) that establish:

5360 (i) the requirements and procedures a contractor and a subcontractor shall follow to

5361 demonstrate compliance with this section, including:

5362 (A) that a contractor or subcontractor's compliance with this section is subject to an

5363 audit by the department or the Office of the Legislative Auditor General;

5364 (B) that a contractor that is subject to the requirements of this section shall obtain a

5365 written statement described in Subsection (5)(a); and

5366 (C) that a subcontractor that is subject to the requirements of this section shall obtain a

5367 written statement described in Subsection (5)(~~b~~)(c)(ii);

5368 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally

5369 violates the provisions of this section, which may include:

5370 (A) a three-month suspension of the contractor or subcontractor from entering into

5371 future contracts with the state upon the first violation;

5372 (B) a six-month suspension of the contractor or subcontractor from entering into future

5373 contracts with the state upon the second violation;

5374 (C) an action for debarment of the contractor or subcontractor in accordance with

5375 Section 63G-6a-904 upon the third or subsequent violation; and

5376 (D) monetary penalties which may not exceed 50% of the amount necessary to

5377 purchase qualified health [insurance] coverage for employees and dependents of employees of

5378 the contractor or subcontractor who were not offered qualified health [insurance] coverage

5379 during the duration of the contract; and

5380 (iii) a website on which the department shall post the commercially equivalent

5381 benchmark, for the qualified health [insurance] coverage identified in Subsection (1)(e), that is

5382 provided by the Department of Health, in accordance with Subsection 26-40-115(2).

5383 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor

5384 or subcontractor who intentionally violates the provisions of this section is liable to the

5385 employee for health care costs that would have been covered by qualified health [insurance]

5386 coverage.

5387 (ii) An employer has an affirmative defense to a cause of action under Subsection  
5388 (7)(a)(i) if:

5389 (A) the employer relied in good faith on a written statement described in Subsection  
5390 (5)(a) or (5)(~~b~~)(c)(ii); or

5391 (B) the department determines that compliance with this section is not required under  
5392 the provisions of Subsection (3).

5393 (b) An employee has a private right of action only against the employee's employer to  
5394 enforce the provisions of this Subsection (7).

5395 (8) Any penalties imposed and collected under this section shall be deposited into the  
5396 Medicaid Restricted Account created in Section 26-18-402.

5397 (9) The failure of a contractor or subcontractor to provide qualified health [insurance]  
5398 coverage as required by this section:

5399 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
5400 or contractor under:

5401 (i) Section 63G-6a-1602; or

5402 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

5403 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
5404 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
5405 or construction.

5406 (10) An administrator, including the administrator's actuary or underwriter, who  
5407 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
5408 coverage of a contractor or subcontractor who provides a health benefit plan described in  
5409 Subsection (1)(d)(ii):

5410 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
5411 unless the administrator commits gross negligence in preparing the written statement;

5412 (b) is not liable for any error in the written statement if the administrator relied in good  
5413 faith on information from the contractor or subcontractor; and

5414 (c) may require as a condition of providing the written statement that a contractor or  
5415 subcontractor hold the administrator harmless for an action arising under this section.

5416 Section 55. Section 72-6-107.5 is amended to read:

5417 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**

5418 **insurance coverage.**

5419 (1) As used in this section:

5420 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
5421 related to a single project.

5422 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

5423 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
5424 "operative" who:

5425 (i) works at least 30 hours per calendar week; and

5426 (ii) meets employer eligibility waiting requirements for health care insurance, which  
5427 may not exceed the first day of the calendar month following 60 days after the day on which  
5428 the individual is hired.

5429 (d) "Health benefit plan" means:

5430 (i) the same as that term is defined in Section [31A-1-301](#)[-]; or

5431 (ii) an employee welfare benefit plan:

5432 (A) established under the Employee Retirement Income Security Act of 1974, 29  
5433 U.S.C. Sec. 1001 et seq.;

5434 (B) for an employer with 100 or more employees; and

5435 (C) in which the employer establishes a self-funded or partially self-funded group  
5436 health plan to provide medical care for the employer's employees and dependents of the  
5437 employees.

5438 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in  
5439 Section [26-40-115](#).

5440 (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).

5441 (g) "Third party administrator" or "administrator" means the same as that term is  
5442 defined in Section [31A-1-301](#).

5443 (2) Except as provided in Subsection (3), the requirements of this section apply to:

5444 (a) a contractor of a design or construction contract entered into by the department on  
5445 or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than  
5446 \$2,000,000; and

5447 (b) a subcontractor of a contractor of a design or construction contract entered into by  
5448 the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or



5449 greater than \$1,000,000.

5450 (3) The requirements of this section do not apply to a contractor or subcontractor  
5451 described in Subsection (2) if:

5452 (a) the application of this section jeopardizes the receipt of federal funds;

5453 (b) the contract is a sole source contract; or

5454 (c) the contract is an emergency procurement.

5455 (4) A person that intentionally uses change orders, contract modifications, or multiple  
5456 contracts to circumvent the requirements of this section is guilty of an infraction.

5457 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the  
5458 department that the contractor has and will maintain an offer of qualified health [~~insurance~~]  
5459 coverage for the contractor's employees and the employees' dependents during the duration of  
5460 the contract by submitting to the department a written statement that:

5461 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with  
5462 Section [26-40-115](#);

5463 (ii) is from:

5464 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

5465 (B) an underwriter who is responsible for developing the employer group's premium  
5466 rates; [~~and~~] or

5467 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
5468 an actuary or underwriter selected by a third party administrator; and

5469 (iii) was created within one year before the day on which the statement is submitted.

5470 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)  
5471 shall provide the actuary or underwriter selected by an administrator, as described in  
5472 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
5473 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the  
5474 requirements of qualified health coverage.

5475 (ii) A contractor may not make a change to the contractor's contribution to the health  
5476 benefit plan, unless the contractor provides notice to:

5477 (A) the actuary or underwriter selected by an administrator, as described in Subsection  
5478 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
5479 Subsection (5)(a) in compliance with this section; and

5480 (B) the department.

5481 ~~[(b)]~~ (c) A contractor that is subject to the requirements of this section shall:

5482 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that  
5483 is subject to the requirements of this section shall obtain and maintain an offer of qualified  
5484 health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents  
5485 during the duration of the subcontract; and

5486 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
5487 written statement that:

5488 (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with  
5489 Section [26-40-115](#);

5490 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, ~~[or]~~  
5491 an underwriter who is responsible for developing the employer group's premium rates, or if the  
5492 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or  
5493 underwriter selected by an administrator; and

5494 (C) was created within one year before the day on which the contractor obtains the  
5495 statement.

5496 ~~[(e)]~~ (d) (i) (A) A contractor that fails to maintain an offer of qualified health  
5497 [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is  
5498 subject to penalties in accordance with administrative rules adopted by the department under  
5499 Subsection (6).

5500 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
5501 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection  
5502 (5)~~[(b)]~~(c)(i).

5503 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
5504 [~~insurance~~] coverage described in Subsection (5)~~[(b)]~~(c) during the duration of the subcontract  
5505 is subject to penalties in accordance with administrative rules adopted by the department under  
5506 Subsection (6).

5507 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
5508 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

5509 (6) The department shall adopt administrative rules:

5510 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

- 5511 (b) in coordination with:
- 5512 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
- 5513 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
- 5514 (iii) the State Building Board in accordance with Section 63A-5-205.5;
- 5515 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
- 5516 (v) a public transit district in accordance with Section 17B-2a-818.5; and
- 5517 (vi) the Legislature's Administrative Rules Review Committee; and
- 5518 (c) that establish:
- 5519 (i) the requirements and procedures a contractor and a subcontractor shall follow to
- 5520 demonstrate compliance with this section, including:
- 5521 (A) that a contractor or subcontractor's compliance with this section is subject to an
- 5522 audit by the department or the Office of the Legislative Auditor General;
- 5523 (B) that a contractor that is subject to the requirements of this section shall obtain a
- 5524 written statement described in Subsection (5)(a); and
- 5525 (C) that a subcontractor that is subject to the requirements of this section shall obtain a
- 5526 written statement described in Subsection (5)(~~b~~)(c)(ii);
- 5527 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
- 5528 violates the provisions of this section, which may include:
- 5529 (A) a three-month suspension of the contractor or subcontractor from entering into
- 5530 future contracts with the state upon the first violation;
- 5531 (B) a six-month suspension of the contractor or subcontractor from entering into future
- 5532 contracts with the state upon the second violation;
- 5533 (C) an action for debarment of the contractor or subcontractor in accordance with
- 5534 Section 63G-6a-904 upon the third or subsequent violation; and
- 5535 (D) monetary penalties which may not exceed 50% of the amount necessary to
- 5536 purchase qualified health [~~insurance~~] coverage for an employee and a dependent of the
- 5537 employee of the contractor or subcontractor who was not offered qualified health [~~insurance~~]
- 5538 coverage during the duration of the contract; and
- 5539 (iii) a website on which the department shall post the commercially equivalent
- 5540 benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is
- 5541 provided by the Department of Health, in accordance with Subsection 26-40-115(2).

5542 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
5543 or subcontractor who intentionally violates the provisions of this section is liable to the  
5544 employee for health care costs that would have been covered by qualified health [insurance]  
5545 coverage.

5546 (ii) An employer has an affirmative defense to a cause of action under Subsection  
5547 (7)(a)(i) if:

5548 (A) the employer relied in good faith on a written statement described in Subsection  
5549 (5)(a) or (5)(~~b~~)(c)(ii); or

5550 (B) the department determines that compliance with this section is not required under  
5551 the provisions of Subsection (3).

5552 (b) An employee has a private right of action only against the employee's employer to  
5553 enforce the provisions of this Subsection (7).

5554 (8) Any penalties imposed and collected under this section shall be deposited into the  
5555 Medicaid Restricted Account created in Section 26-18-402.

5556 (9) The failure of a contractor or subcontractor to provide qualified health [insurance]  
5557 coverage as required by this section:

5558 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
5559 or contractor under:

5560 (i) Section 63G-6a-1602; or

5561 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

5562 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
5563 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
5564 or construction.

5565 (10) An administrator, including an administrator's actuary or underwriter, who  
5566 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
5567 coverage of a contractor or subcontractor who provides a health benefit plan described in  
5568 Subsection (1)(d)(ii):

5569 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
5570 unless the administrator commits gross negligence in preparing the written statement;

5571 (b) is not liable for any error in the written statement if the administrator relied in good  
5572 faith on information from the contractor or subcontractor; and

5573 (c) may require as a condition of providing the written statement that a contractor or  
5574 subcontractor hold the administrator harmless for an action arising under this section.

5575 Section 56. Section **79-2-404** is amended to read:

5576 **79-2-404. Contracting powers of department -- Health insurance coverage.**

5577 (1) As used in this section:

5578 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
5579 related to a single project.

5580 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

5581 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
5582 "operative" who:

5583 (i) works at least 30 hours per calendar week; and

5584 (ii) meets employer eligibility waiting requirements for health care insurance, which  
5585 may not exceed the first day of the calendar month following 60 days after the day on which  
5586 the individual is hired.

5587 (d) "Health benefit plan" means:

5588 (i) the same as that term is defined in Section [31A-1-301](#)[-]; or

5589 (ii) an employee welfare benefit plan:

5590 (A) established under the Employee Retirement Income Security Act of 1974, 29

5591 U.S.C. Sec. 1001 et seq.;

5592 (B) for an employer with 100 or more employees; and

5593 (C) in which the employer establishes a self-funded or partially self-funded group  
5594 health plan to provide medical care for the employer's employees and dependents of the  
5595 employees.

5596 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in  
5597 Section [26-40-115](#).

5598 (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).

5599 (g) "Third party administrator" or "administrator" means the same as that term is  
5600 defined in Section [31A-1-301](#).

5601 (2) Except as provided in Subsection (3), the requirements of this section apply to:

5602 (a) a contractor of a design or construction contract entered into by, or delegated to, the  
5603 department or a division, board, or council of the department on or after July 1, 2009, if the

5604 prime contract is in an aggregate amount equal to or greater than \$2,000,000; and

5605 (b) a subcontractor of a contractor of a design or construction contract entered into by,  
5606 or delegated to, the department or a division, board, or council of the department on or after  
5607 July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than \$1,000,000.

5608 (3) This section does not apply to contracts entered into by the department or a  
5609 division, board, or council of the department if:

5610 (a) the application of this section jeopardizes the receipt of federal funds;

5611 (b) the contract or agreement is between:

5612 (i) the department or a division, board, or council of the department; and

5613 (ii) (A) another agency of the state;

5614 (B) the federal government;

5615 (C) another state;

5616 (D) an interstate agency;

5617 (E) a political subdivision of this state; or

5618 (F) a political subdivision of another state; or

5619 (c) the contract or agreement is:

5620 (i) for the purpose of disbursing grants or loans authorized by statute;

5621 (ii) a sole source contract; or

5622 (iii) an emergency procurement.

5623 (4) A person that intentionally uses change orders, contract modifications, or multiple  
5624 contracts to circumvent the requirements of this section is guilty of an infraction.

5625 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the  
5626 department that the contractor has and will maintain an offer of qualified health [~~insurance~~]  
5627 coverage for the contractor's employees and the employees' dependents during the duration of  
5628 the contract by submitting to the department a written statement that:

5629 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with  
5630 Section [26-40-115](#);

5631 (ii) is from:

5632 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

5633 (B) an underwriter who is responsible for developing the employer group's premium  
5634 rates; [~~and~~] or

5635 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
5636 an actuary or underwriter selected by a third party administrator; and  
5637 (iii) was created within one year before the day on which the statement is submitted.

5638 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)  
5639 shall provide the actuary or underwriter selected by an administrator, as described in  
5640 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
5641 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the  
5642 requirements of qualified health coverage.

5643 (ii) A contractor may not make a change to the contractor's contribution to the health  
5644 benefit plan, unless the contractor provides notice to:

5645 (A) the actuary or underwriter selected by an administrator, as described in Subsection  
5646 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
5647 Subsection (5)(a) in compliance with this section; and

5648 (B) the department.

5649 ~~(b)~~ (c) A contractor that is subject to the requirements of this section shall:

5650 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that  
5651 is subject to the requirements of this section shall obtain and maintain an offer of qualified  
5652 health ~~[insurance]~~ coverage for the subcontractor's employees and the employees' dependents  
5653 during the duration of the subcontract; and

5654 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
5655 written statement that:

5656 (A) the subcontractor offers qualified health ~~[insurance]~~ coverage that complies with  
5657 Section [26-40-115](#);

5658 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, ~~[or]~~  
5659 an underwriter who is responsible for developing the employer group's premium rates, or if the  
5660 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or  
5661 underwriter selected by an administrator; and

5662 (C) was created within one year before the day on which the contractor obtains the  
5663 statement.

5664 ~~(c)~~ (d) (i) (A) A contractor that fails to maintain an offer of qualified health  
5665 ~~[insurance]~~ coverage described in Subsection (5)(a) during the duration of the contract is

5666 subject to penalties in accordance with administrative rules adopted by the department under  
5667 Subsection (6).

5668 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
5669 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection  
5670 (5)[~~(b)~~](c)(i).

5671 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
5672 [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c) during the duration of the subcontract  
5673 is subject to penalties in accordance with administrative rules adopted by the department under  
5674 Subsection (6).

5675 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
5676 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

5677 (6) The department shall adopt administrative rules:

5678 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

5679 (b) in coordination with:

5680 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

5681 (ii) a public transit district in accordance with Section 17B-2a-818.5;

5682 (iii) the State Building Board in accordance with Section 63A-5-205.5;

5683 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

5684 (v) the Department of Transportation in accordance with Section 72-6-107.5; and

5685 (vi) the Legislature's Administrative Rules Review Committee; and

5686 (c) that establish:

5687 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
5688 demonstrate compliance with this section, including:

5689 (A) that a contractor or subcontractor's compliance with this section is subject to an  
5690 audit by the department or the Office of the Legislative Auditor General;

5691 (B) that a contractor that is subject to the requirements of this section shall obtain a  
5692 written statement described in Subsection (5)(a); and

5693 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
5694 written statement described in Subsection (5)[~~(b)~~](c)(ii);

5695 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
5696 violates the provisions of this section, which may include:



- 5697 (A) a three-month suspension of the contractor or subcontractor from entering into  
5698 future contracts with the state upon the first violation;
- 5699 (B) a six-month suspension of the contractor or subcontractor from entering into future  
5700 contracts with the state upon the second violation;
- 5701 (C) an action for debarment of the contractor or subcontractor in accordance with  
5702 Section [63G-6a-904](#) upon the third or subsequent violation; and
- 5703 (D) monetary penalties which may not exceed 50% of the amount necessary to  
5704 purchase qualified health [~~insurance~~] coverage for an employee and a dependent of an  
5705 employee of the contractor or subcontractor who was not offered qualified health [~~insurance~~]  
5706 coverage during the duration of the contract; and
- 5707 (iii) a website on which the department shall post the commercially equivalent  
5708 benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e),  
5709 provided by the Department of Health, in accordance with Subsection [26-40-115](#)(2).
- 5710 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
5711 or subcontractor who intentionally violates the provisions of this section is liable to the  
5712 employee for health care costs that would have been covered by qualified health [~~insurance~~]  
5713 coverage.
- 5714 (ii) An employer has an affirmative defense to a cause of action under Subsection  
5715 (7)(a)(i) if:
- 5716 (A) the employer relied in good faith on a written statement described in Subsection  
5717 (5)(a) or (5)(~~b~~)(c)(ii); or
- 5718 (B) the department determines that compliance with this section is not required under  
5719 the provisions of Subsection (3).
- 5720 (b) An employee has a private right of action only against the employee's employer to  
5721 enforce the provisions of this Subsection (7).
- 5722 (8) Any penalties imposed and collected under this section shall be deposited into the  
5723 Medicaid Restricted Account created in Section [26-18-402](#).
- 5724 (9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~]  
5725 coverage as required by this section:
- 5726 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
5727 or contractor under:

5728 (i) Section 63G-6a-1602; or  
5729 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and  
5730 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
5731 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
5732 or construction.

5733 (10) An administrator, including an administrator's actuary or underwriter, who  
5734 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
5735 coverage of a contractor or subcontractor who provides a health benefit plan described in  
5736 Subsection (1)(d)(ii):

5737 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
5738 unless the administrator commits gross negligence in preparing the written statement;

5739 (b) is not liable for any error in the written statement if the administrator relied in good  
5740 faith on information from the contractor or subcontractor; and

5741 (c) may require as a condition of providing the written statement that a contractor or  
5742 subcontractor hold the administrator harmless for an action arising under this section.