LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: P. Grecu ₵
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INSURANCE AMENDMENTS

2022 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

Committee Note:

The Business and Labor Interim Committee recommended this bill.

Legislative Vote: 16 voting for 0 voting against 5 absent

General Description:

This bill amends the Insurance Code.

Highlighted Provisions:

This bill:

- amends definitions;
- defines terms;
- modifies provisions regarding Title and Escrow Commission meetings;
- amends required disclosures for a service contract and vehicle protection product warranty;
- amends provisions related to the registration of insurers;
- requires a large insurance holding company to submit to the Insurance Department a Group Capital Calculation and Liquidity Stress Test results;
- amends provisions regarding the standards and management of an insurer within a holding company system;
- amends provisions related to the confidentiality of certain information obtained by the Utah Insurance Commissioner (commissioner);
- allows an unearned premium reserve fund to be released in accordance with the

H.B. 31

standards of the National Association of Insurance Commissioners;

- amends provisions regarding title insurance;
- amends insurance form requirements;
- amends provisions regarding insurance policy renewal notification requirements;
- amends provisions related to an arbitration decision's resolution of a claim under an underinsured motorist policy;
- amends provisions related to accident and health insurance;
- enacts provisions related to the renewal, cancellation, and modification of a group accident and health insurance plan;
- allows the commissioner to take action against a license of an insurance producer who fails to pay a final judgment rendered against the insurance producer by a court outside of this state;
- makes an affiliate of an insolvent insurer subject to Title 31A, Chapter 27a, Insurer Receivership Act;
- amends provisions related to a defense to a claim by a receiver;
- amends provisions related to a bail bond agency's required financial statements;
- provides a sunset date for provisions of this bill, subject to review;
- amends the criminal offense of fraudulent insurance act; and
- makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26-61a-201, as last amended by Laws of Utah 2021, Chapters 17 and further amended by Revisor Instructions, Laws of Utah 2021, Chapters 337, 337, and 350

26-61a-204, as last amended by Laws of Utah 2021, Chapter 350

31A-1-301, as last amended by Laws of Utah 2021, Second Special Session, Chapter 4

31A-2-403, as last amended by Laws of Utah 2020, Chapters 32, 352, and 373

31A-6a-104, as last amended by Laws of Utah 2020, Chapter 32

31A-16-105, as last amended by Laws of Utah 2017, Chapter 168
31A-16-106, as last amended by Laws of Utah 2015, Chapter 244
31A-16-109, as last amended by Laws of Utah 2019, Chapter 193
31A-17-408, as last amended by Laws of Utah 2001, Chapter 116
31A-17-601, as last amended by Laws of Utah 2020, Chapter 32
31A-19a-209, as last amended by Laws of Utah 2015, Chapters 312 and 330
31A-21-201, as last amended by Laws of Utah 2021, Chapter 252
31A-21-303, as last amended by Laws of Utah 2020, Chapter 292
31A-22-305.3, as last amended by Laws of Utah 2020, Chapter 145
31A-22-602, as last amended by Laws of Utah 2021, Chapter 252
31A-22-627, as last amended by Laws of Utah 2021, Chapter 252
31A-23a-111, as last amended by Laws of Utah 2020, Chapter 32
31A-27a-104, as last amended by Laws of Utah 2013, Chapter 319
31A-27a-111, as last amended by Laws of Utah 2018, Chapter 319
31A-30-103, as last amended by Laws of Utah 2019, Chapter 193
31A-35-404, as last amended by Laws of Utah 2021, Chapter 252
58-13-2.5, as enacted by Laws of Utah 2009, Chapter 14
63I-1-231, as last amended by Laws of Utah 2019, Chapter 136
76-6-521, as last amended by Laws of Utah 2019, Chapter 193

ENACTS:

31A-22-727, Utah Code Annotated 1953

REPEALS:

31A-17-519, as last amended by Laws of Utah 2019, Chapter 193

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

Section 1. Section **26-61a-201** is amended to read:

26-61a-201. Medical cannabis patient card -- Medical cannabis guardian card -- Conditional medical cannabis card -- Application -- Fees -- Studies.

(1) (a) The department shall, within 15 days after the day on which an individual who satisfies the eligibility criteria in this section or Section 26-61a-202 submits an application in accordance with this section or Section 26-61a-202:

(i) issue a medical cannabis patient card to an individual described in Subsection (2)(a);

(ii) issue a medical cannabis guardian card to an individual described in Subsection (2)(b);

(iii) issue a provisional patient card to a minor described in Subsection (2)(c); and

(iv) issue a medical cannabis caregiver card to an individual described in Subsection 26-61a-202(4).

(b) (i) Beginning on the earlier of September 1, 2021, or the date on which the electronic verification system is functionally capable of facilitating a conditional medical cannabis card under this Subsection (1)(b), upon the entry of a recommending medical provider's medical cannabis recommendation for a patient in the state electronic verification system, either by the provider or the provider's employee or by a medical cannabis pharmacy medical provider or medical cannabis pharmacy in accordance with Subsection 26-61a-501(11)(a), the department shall issue to the patient an electronic conditional medical cannabis card, in accordance with this Subsection (1)(b).

(ii) A conditional medical cannabis card is valid for the lesser of:

(A) 60 days; or

(B) the day on which the department completes the department's review and issues a medical cannabis card under Subsection (1)(a), denies the patient's medical cannabis card application, or revokes the conditional medical cannabis card under Subsection (8).

(iii) The department may issue a conditional medical cannabis card to an individual applying for a medical cannabis patient card for which approval of the Compassionate Use Board is not required.

(iv) An individual described in Subsection (1)(b)(iii) has the rights, restrictions, and obligations under law applicable to a holder of the medical cannabis card for which the individual applies and for which the department issues the conditional medical cannabis card.

(2) (a) An individual is eligible for a medical cannabis patient card if:

(i) (A) the individual is at least 21 years old; or

(B) the individual is 18, 19, or 20 years old, the individual petitions the Compassionate Use Board under Section 26-61a-105, and the Compassionate Use Board recommends department approval of the petition;

(ii) the individual is a Utah resident;

(iii) the individual's recommending medical provider recommends treatment with medical cannabis in accordance with Subsection (4);

(iv) the individual signs an acknowledgment stating that the individual received the information described in Subsection (8); and

(v) the individual pays to the department a fee in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504.

(b) (i) An individual is eligible for a medical cannabis guardian card if the individual:

(A) is at least 18 years old;

(B) is a Utah resident;

(C) is the parent or legal guardian of a minor for whom the minor's qualified medical provider recommends a medical cannabis treatment, the individual petitions the Compassionate Use Board under Section 26-61a-105, and the Compassionate Use Board recommends department approval of the petition;

(D) the individual signs an acknowledgment stating that the individual received the information described in Subsection (9);

(E) pays to the department a fee in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504, plus the cost of the criminal background check described in Section 26-61a-203; and

(F) the individual has not been convicted of a misdemeanor or felony drug distribution offense under either state or federal law, unless the individual completed any imposed sentence six months or more before the day on which the individual applies for a medical cannabis guardian card.

(ii) The department shall notify the Department of Public Safety of each individual that the department registers for a medical cannabis guardian card.

(c) (i) A minor is eligible for a provisional patient card if:

(A) the minor has a qualifying condition;

(B) the minor's qualified medical provider recommends a medical cannabis treatment to address the minor's qualifying condition;

(C) one of the minor's parents or legal guardians petitions the Compassionate Use Board under Section 26-61a-105, and the Compassionate Use Board recommends department

approval of the petition; and

(D) the minor's parent or legal guardian is eligible for a medical cannabis guardian card under Subsection (2)(b) or designates a caregiver under Subsection (2)(d) who is eligible for a medical cannabis caregiver card under Section 26-61a-202.

(ii) The department shall automatically issue a provisional patient card to the minor described in Subsection (2)(c)(i) at the same time the department issues a medical cannabis guardian card to the minor's parent or legal guardian.

(d) Beginning on the earlier of September 1, 2021, or the date on which the electronic verification system is functionally capable of servicing the designation, if the parent or legal guardian of a minor described in Subsections (2)(c)(i)(A) through (C) does not qualify for a medical cannabis guardian card under Subsection (2)(b), the parent or legal guardian may designate up to two caregivers in accordance with Subsection 26-61a-202(1)(c) to ensure that the minor has adequate and safe access to the recommended medical cannabis treatment.

(3) (a) An individual who is eligible for a medical cannabis card described in Subsection (2)(a) or (b) shall submit an application for a medical cannabis card to the department:

(i) through an electronic application connected to the state electronic verification system;

(ii) with the recommending medical provider; and

(iii) with information including:

(A) the applicant's name, gender, age, and address;

(B) the number of the applicant's valid form of photo identification;

(C) for a medical cannabis guardian card, the name, gender, and age of the minor receiving a medical cannabis treatment under the cardholder's medical cannabis guardian card; and

(D) for a provisional patient card, the name of the minor's parent or legal guardian who holds the associated medical cannabis guardian card.

(b) The department shall ensure that a medical cannabis card the department issues under this section contains the information described in Subsection (3)(a)(iii).

(c) (i) If a recommending medical provider determines that, because of age, illness, or disability, a medical cannabis patient cardholder requires assistance in administering the

medical cannabis treatment that the recommending medical provider recommends, the recommending medical provider may indicate the cardholder's need in the state electronic verification system, either directly or, for a limited medical provider, through the order described in Subsections 26-61a-106(1)(c) and (d).

(ii) If a recommending medical provider makes the indication described in Subsection (3)(c)(i):

(A) the department shall add a label to the relevant medical cannabis patient card indicating the cardholder's need for assistance;

(B) any adult who is 18 years old or older and who is physically present with the cardholder at the time the cardholder needs to use the recommended medical cannabis treatment may handle the medical cannabis treatment and any associated medical cannabis device as needed to assist the cardholder in administering the recommended medical cannabis treatment; and

(C) an individual of any age who is physically present with the cardholder in the event of an emergency medical condition, as that term is defined in Section [~~31A-22-627~~] 31A-1-301, may handle the medical cannabis treatment and any associated medical cannabis device as needed to assist the cardholder in administering the recommended medical cannabis treatment.

(iii) A non-cardholding individual acting under Subsection (3)(c)(ii)(B) or (C) may not:

(A) ingest or inhale medical cannabis;

(B) possess, transport, or handle medical cannabis or a medical cannabis device outside of the immediate area where the cardholder is present or with an intent other than to provide assistance to the cardholder; or

(C) possess, transport, or handle medical cannabis or a medical cannabis device when the cardholder is not in the process of being dosed with medical cannabis.

(4) To recommend a medical cannabis treatment to a patient or to renew a recommendation, a recommending medical provider shall:

(a) before recommending or renewing a recommendation for medical cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form:

(i) verify the patient's and, for a minor patient, the minor patient's parent or legal guardian's valid form of identification described in Subsection (3)(a);

(ii) review any record related to the patient and, for a minor patient, the patient's parent or legal guardian in:

(A) for a qualified medical provider, the state electronic verification system; and

(B) the controlled substance database created in Section 58-37f-201; and

(iii) consider the recommendation in light of the patient's qualifying condition and history of medical cannabis and controlled substance use during an initial face-to-face visit with the patient; and

(b) state in the recommending medical provider's recommendation that the patient:

(i) suffers from a qualifying condition, including the type of qualifying condition; and

(ii) may benefit from treatment with cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form.

(5) (a) Except as provided in Subsection (5)(b), a medical cannabis card that the department issues under this section is valid for the lesser of:

(i) an amount of time that the recommending medical provider determines; or

(ii) (A) six months for the first issuance, and, except as provided in Subsection (5)(a)(ii)(B), for a renewal; or

(B) for a renewal, one year if, after at least one year following the issuance of the original medical cannabis card, the recommending medical provider determines that the patient has been stabilized on the medical cannabis treatment and a one-year renewal period is justified.

(b) (i) A medical cannabis card that the department issues in relation to a terminal illness described in Section 26-61a-104 does not expire.

(ii) The recommending medical provider may revoke a recommendation that the provider made in relation to a terminal illness described in Section 26-61a-104 if the medical cannabis cardholder no longer has the terminal illness.

(6) (a) A medical cannabis patient card or a medical cannabis guardian card is renewable if:

(i) at the time of renewal, the cardholder meets the requirements of Subsection (2)(a) or (b); or

(ii) the cardholder received the medical cannabis card through the recommendation of the Compassionate Use Board under Section 26-61a-105.

(b) A cardholder described in Subsection (6)(a) may renew the cardholder's card:

(i) using the application process described in Subsection (3); or

(ii) through phone or video conference with the recommending medical provider who made the recommendation underlying the card, at the qualifying medical provider's discretion.

(c) A cardholder under Subsection (2)(a) or (b) who renews the cardholder's card shall pay to the department a renewal fee in an amount that:

(i) subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504; and

(ii) may not exceed the cost of the relatively lower administrative burden of renewal in comparison to the original application process.

(d) If a minor meets the requirements of Subsection (2)(c), the minor's provisional patient card renews automatically at the time the minor's parent or legal guardian renews the parent or legal guardian's associated medical cannabis guardian card.

(7) (a) A cardholder under this section shall carry the cardholder's valid medical cannabis card with the patient's name.

(b) (i) A medical cannabis patient cardholder or a provisional patient cardholder may purchase, in accordance with this chapter and the recommendation underlying the card, cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device.

(ii) A cardholder under this section may possess or transport, in accordance with this chapter and the recommendation underlying the card, cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device.

(iii) To address the qualifying condition underlying the medical cannabis treatment recommendation:

(A) a medical cannabis patient cardholder or a provisional patient cardholder may use cannabis in a medicinal dosage form, a medical cannabis product in a medicinal dosage form, or a medical cannabis device; and

(B) a medical cannabis guardian cardholder may assist the associated provisional patient cardholder with the use of cannabis in a medicinal dosage form, a medical cannabis product in a medicinal dosage form, or a medical cannabis device.

(c) If a licensed medical cannabis pharmacy is not operating within the state after

January 1, 2021, a cardholder under this section:

(i) may possess:

(A) up to the legal dosage limit of unprocessed cannabis in a medicinal dosage form;

(B) up to the legal dosage limit of a cannabis product in a medicinal dosage form; and

(C) marijuana drug paraphernalia; and

(ii) is not subject to prosecution for the possession described in Subsection (7)(c)(i).

(8) The department may revoke a medical cannabis card that the department issues under this section if the cardholder:

(a) violates this chapter; or

(b) is convicted under state or federal law of:

(i) a felony; or

(ii) after March 17, 2021, a misdemeanor for drug distribution.

(9) The department shall establish by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, a process to provide information regarding the following to an individual receiving a medical cannabis card:

(a) risks associated with medical cannabis treatment;

(b) the fact that a condition's listing as a qualifying condition does not suggest that medical cannabis treatment is an effective treatment or cure for that condition, as described in Subsection 26-61a-104(1); and

(c) other relevant warnings and safety information that the department determines.

(10) The department may establish procedures by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the application and issuance provisions of this section.

(11) (a) On or before September 1, 2021, the department shall establish by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, a process to allow an individual from another state to register with the department in order to purchase medical cannabis or a medical cannabis device from a medical cannabis pharmacy while the individual is visiting the state.

(b) The department may only provide the registration process described in Subsection (11)(a):

(i) to a nonresident patient; and

(ii) for no more than two visitation periods per calendar year of up to 21 calendar days per visitation period.

(12) (a) A person may submit to the department a request to conduct a research study using medical cannabis cardholder data that the state electronic verification system contains.

(b) The department shall review a request described in Subsection (12)(a) to determine whether an institutional review board, as that term is defined in Section 26-61-102, could approve the research study.

(c) At the time an individual applies for a medical cannabis card, the department shall notify the individual:

(i) of how the individual's information will be used as a cardholder;

(ii) that by applying for a medical cannabis card, unless the individual withdraws consent under Subsection (12)(d), the individual consents to the use of the individual's information for external research; and

(iii) that the individual may withdraw consent for the use of the individual's information for external research at any time, including at the time of application.

(d) An applicant may, through the medical cannabis card application, and a medical cannabis cardholder may, through the state central patient portal, withdraw the applicant's or cardholder's consent to participate in external research at any time.

(e) The department may release, for the purposes of a study described in this Subsection (12), information about a cardholder under this section who consents to participate under Subsection (12)(c).

(f) If an individual withdraws consent under Subsection (12)(d), the withdrawal of consent:

(i) applies to external research that is initiated after the withdrawal of consent; and

(ii) does not apply to research that was initiated before the withdrawal of consent.

(g) The department may establish standards for a medical research study's validity, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(13) The department shall record the issuance or revocation of a medical cannabis card under this section in the controlled substance database.

Section 2. Section **26-61a-204** is amended to read:

26-61a-204. Medical cannabis card -- Patient and designated caregiver

requirements -- Rebuttable presumption.

(1) (a) A medical cannabis cardholder who possesses medical cannabis that the cardholder purchased under this chapter:

(i) shall carry:

(A) at all times the cardholder's medical cannabis card; and

(B) after the earlier of January 1, 2021, or the day on which the individual purchases any medical cannabis from a medical cannabis pharmacy, with the medical cannabis, a label that identifies that the medical cannabis was sold from a licensed medical cannabis pharmacy and includes an identification number that links the medical cannabis to the inventory control system; [~~and~~]

(ii) may possess up to the legal dosage limit of:

(A) unprocessed cannabis in medicinal dosage form; and

(B) a cannabis product in medicinal dosage form;

(iii) may not possess more medical cannabis than described in Subsection (1)(a)(ii);

(iv) may only possess the medical cannabis in the container in which the cardholder received the medical cannabis from the medical cannabis pharmacy; and

(v) may not alter or remove any label described in Section 4-41a-602 from the container described in Subsection (1)(a)(iv).

(b) Except as provided in Subsection (1)(c) or (e), a medical cannabis cardholder who possesses medical cannabis in violation of Subsection (1)(a) is:

(i) guilty of an infraction; and

(ii) subject to a $100 fine.

(c) A medical cannabis cardholder or a nonresident patient who possesses medical cannabis in an amount that is greater than the legal dosage limit and equal to or less than twice the legal dosage limit is:

(i) for a first offense:

(A) guilty of an infraction; and

(B) subject to a fine of up to $100; and

(ii) for a second or subsequent offense:

(A) guilty of a class B misdemeanor; and

(B) subject to a fine of $1,000.

(d) An individual who is guilty of a violation described in Subsection (1)(b) or (c) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the penalty described in Subsection (1)(b) or (c).

(e) A nonresident patient who possesses medical cannabis that is not in a medicinal dosage form is:

(i) for a first offense:

(A) guilty of an infraction; and

(B) subject to a fine of up to $100; and

(ii) for a second or subsequent offense, is subject to the penalties described in Title 58, Chapter 37, Utah Controlled Substances Act.

(f) A medical cannabis cardholder or a nonresident patient who possesses medical cannabis in an amount that is greater than twice the legal dosage limit is subject to the penalties described in Title 58, Chapter 37, Utah Controlled Substances Act.

(2) (a) As used in this Subsection (2), "emergency medical condition" means the same as that term is defined in Section [~~31A-22-627~~] 31A-1-301.

(b) Except as described in Subsection (2)(c), a medical cannabis patient cardholder, a provisional patient cardholder, or a nonresident patient may not use, in public view, medical cannabis or a cannabis product.

(c) In the event of an emergency medical condition, an individual described in Subsection (2)(b) may use, and the holder of a medical cannabis guardian card or a medical cannabis caregiver card may administer to the cardholder's charge, in public view, cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form.

(d) An individual described in Subsection (2)(b) who violates Subsection (2)(b) is:

(i) for a first offense:

(A) guilty of an infraction; and

(B) subject to a fine of up to $100; and

(ii) for a second or subsequent offense:

(A) guilty of a class B misdemeanor; and

(B) subject to a fine of $1,000.

(3) If a medical cannabis cardholder carrying the cardholder's card possesses cannabis in a medicinal dosage form or a cannabis product in compliance with Subsection (1), or a

medical cannabis device that corresponds with the cannabis or cannabis product:

(a) there is a rebuttable presumption that the cardholder possesses the cannabis, cannabis product, or medical cannabis device legally; and

(b) there is no probable cause, based solely on the cardholder's possession of the cannabis in medicinal dosage form, cannabis product in medicinal dosage form, or medical cannabis device, to believe that the cardholder is engaging in illegal activity.

(4) (a) If a law enforcement officer stops an individual who possesses cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device, and the individual represents to the law enforcement officer that the individual holds a valid medical cannabis card, but the individual does not have the medical cannabis card in the individual's possession at the time of the stop by the law enforcement officer, the law enforcement officer shall attempt to access the state electronic verification system to determine whether the individual holds a valid medical cannabis card.

(b) If the law enforcement officer is able to verify that the individual described in Subsection (4)(a) is a valid medical cannabis cardholder, the law enforcement officer:

(i) may not arrest or take the individual into custody for the sole reason that the individual is in possession of cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device; and

(ii) may not seize the cannabis, cannabis product, or medical cannabis device.

Section 3. Section **31A-1-301** is amended to read:

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) [~~an expense reimbursement~~] a fixed indemnity contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

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

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

(3) "Administrator" means the same as that term is defined in Subsection [~~(178)~~] (182).

(4) "Adult" means an individual who [~~has attained the age of at least 18 years~~] is 18 years old or older.

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

(6) "Agency" means:

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

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

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

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

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

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

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

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

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

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

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

(12) "Bail bond insurance" means a guarantee that a person will attend court when required, up to and including surrender of the person in execution of a sentence imposed under Subsection 77-20-501(1), as a condition to the release of that person from confinement.

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

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

(a) without individual underwriting or application; and

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

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

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

(a) that is open to the public;

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

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

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(18) "Business of insurance" means the same as that term is defined in Subsection [~~(94)~~] (95).

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

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

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

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

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

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by a parent organization; and

(ii) whose purpose is to insure risks of the parent organization and other risks as authorized under:

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

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

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

(i) owned by the insureds; and

(ii) whose purpose is to insure risks of:

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

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

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

(b) a third party.

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

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

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

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

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

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

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

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

(A) for the life of the insured; or

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

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

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

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

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

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

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

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

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

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

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

Disclosure Act.

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

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

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

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

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

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

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

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

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

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

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(40) "Credit property insurance" means insurance:

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

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

(41) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

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

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

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

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

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

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

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

take a specific action.

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

(47) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(50) "Disability income insurance" means the same as that term is defined in Subsection [~~(85)~~] (86).

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

(ii) a person described in Subsection (53)(b).

(b) "Eligible employee" includes:

(i) an [~~owner~~] individual who:

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

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

[~~(C) employs at least one common employee; and~~]

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

(A) an owner who employs at least one common employee;

[~~(A)~~] (B) a sole proprietor;

[~~(B)~~] (C) a partner in a partnership; or

[~~(C)~~] (D) an independent contractor.

(c) "Eligible employee" does not include[~~, unless eligible under Subsection (53)(b)~~]:

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

(ii) an employer's spouse who does not meet the requirements of Subsection (53)(a)[~~(i)~~] or (b); or

(iii) a dependent of an employer who does not meet the requirements of Subsection (53)(a)[~~(i)~~] or (b).

(54) "Emergency medical condition" means a medical condition that:

(a) manifests itself by acute symptoms, including severe pain; and

(b) would cause a prudent layperson possessing an average knowledge of medicine and health to reasonably expect the absence of immediate medical attention through a hospital emergency department to result in:

(i) placing the layperson's health or the layperson's unborn child's health in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

[~~(54)~~] (55) "Employee" means:

(a) an individual employed by an employer; [~~and~~] or

(b) an [~~owner~~] individual who meets the requirements of Subsection (53)(b)[~~(i)~~].

[~~(55)~~] (56) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

[~~(56)~~] (57) (a) "Employee welfare fund" means a fund:

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

(A) one or more employers;

(B) one or more labor organizations; or

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

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

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

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

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

[~~(57)~~] (58) "Endorsement" means a written agreement attached to a policy or certificate to modify the policy or certificate coverage.

[~~(58)~~] (59) (a) "Enrollee" means:

(i) a policyholder;

(ii) a certificate holder;

(iii) a subscriber; or

(iv) a covered individual:

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

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

(b) "Enrollee" includes an insured.

[~~(59)~~] (60) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or

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

[~~(60)~~] (61) "Enterprise risk" means an activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything that would cause:

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

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

[~~(61)~~] (62) (a) "Escrow" means:

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

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

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

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" does not include:

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

(A) an acknowledgment;

(B) a copy certification;

(C) jurat; and

(D) an oath or affirmation;

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

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

[~~(62)~~] (63) "Escrow agent" means an agency title insurance producer meeting the requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an individual title insurance producer licensed with an escrow subline of authority.

[~~(63)~~] (64) (a) "Excludes" is not exhaustive and does not mean that another thing is not also excluded.

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

[~~(64)~~] (65) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

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

[~~(65) "Expense reimbursement insurance" means insurance:~~]

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

[~~(b) written:~~]

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

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

(66) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding a position of public or private trust.

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

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

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

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

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

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection (67)(a).

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

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement;

(o) a binder; or

(p) an outline of coverage.

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

(70) (a) "Fixed indemnity insurance" means accident and health insurance written to provide a fixed amount for a specified event relating to or resulting from an illness or injury.

(b) "Fixed indemnity insurance" includes hospital confinement indemnity insurance.

[~~(70)~~] (71) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(71)~~] (72) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

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

[~~(72)~~] (73) "Franchise insurance" means an individual insurance policy provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

[~~(73)~~] (74) "General lines of authority" include:

(a) the general lines of insurance in Subsection [~~(74)~~] (75);

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

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

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

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

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

[~~(74)~~] (75) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

[~~(75)~~] (76) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

[~~(76)~~] (77) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

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

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

(A) the policy; or

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

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

[~~(77)~~] (78) "Group-wide supervisor" means the commissioner or other regulatory official designated as the group-wide supervisor for an internationally active insurance group under Section 31A-16-108.6.

[~~(78)~~] (79) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the

insurance settlement and the balance of the loan if the insured automobile is a total loss.

[~~(79)~~] (80) (a) "Health benefit plan" means[~~, except as provided in Subsection (79)(b),~~] a policy, contract, certificate, or agreement offered or issued by [~~a health carrier~~] an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care, including major medical expense coverage.

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

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

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

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

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics;

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

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

(A) limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

(xii) short-term limited duration health insurance; and

(xiii) student health insurance, except as required under 45 C.F.R. Sec. 147.145.

[~~(80)~~] (81) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

[~~(81)~~] (82) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

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

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

[~~(82)~~] (83) "Health care provider" means the same as that term is defined in Section 78B-3-403.

[~~(83)~~] (84) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec. 155.20.

[~~(84)~~] (85) "Health Insurance Portability and Accountability Act" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.

[~~(85)~~] (86) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(86)~~] (87) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(87)~~] (88) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

[~~(88)~~] (89) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(89)~~] (90) "Individual" means a natural person.

[~~(90)~~] (91) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

[~~(91)~~] (92) "Insolvency" or "insolvent" means that:

(a) an insurer is unable to pay the insurer's obligations as the obligations are due;

(b) an insurer's total adjusted capital is less than the insurer's mandatory control level

RBC under Subsection 31A-17-601(8)(c); or

(c) an insurer's admitted assets are less than the insurer's liabilities.

[~~(92)~~] (93) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

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

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

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

[~~(93)~~] (94) "Insurance adjuster" means a person who directs or conducts the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(94)~~] (95) "Insurance business" or "business of insurance" includes:

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

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

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

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

(c) providing an annuity:

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

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

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

~~(125)~~];

(e) providing another person with insurance;

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections [~~(94)~~] (95)(a) through (h) in a manner designed to evade this title.

[~~(95)~~] (96) "Insurance consultant" or "consultant" means a person who:

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

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

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

[~~(96)~~] (97) "Insurance group" means the persons that comprise an insurance holding company system.

[~~(97)~~] (98) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

[~~(98)~~] (99) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

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

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

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

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

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

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

[~~(99)~~] (100) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection [~~(99)~~] (100)(a):

(i) applies only to this title;

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

(iii) includes an enrollee.

[~~(100)~~] (101) (a) "Insurer," "carrier," "insurance carrier," or "insurance company" means a person doing an insurance business as a principal including:

(i) a fraternal benefit society;

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

(iii) a motor club;

(iv) an employee welfare plan;

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

(vi) a health maintenance organization.

(b) "Insurer," "carrier," "insurance carrier," or "insurance company" does not include a governmental entity.

[~~(101)~~] (102) "Interinsurance exchange" means the same as that term is defined in Subsection [~~(160)~~] (163).

[~~(102)~~] (103) "Internationally active insurance group" means an insurance holding

company system:

(a) that includes an insurer registered under Section 31A-16-105;

(b) that has premiums written in at least three countries;

(c) whose percentage of gross premiums written outside the United States is at least 10% of its total gross written premiums; and

(d) that, based on a three-year rolling average, has:

(i) total assets of at least $50,000,000,000; or

(ii) total gross written premiums of at least $10,000,000,000.

[~~(103)~~] (104) "Involuntary unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

[~~(104)~~] (105) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

[~~(105)~~] (106) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

[~~(106)~~] (107) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

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

(b) through special enrollment.

[~~(107)~~] (108) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal expense.

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

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

[~~(108)~~] (109) (a) "Liability insurance" means insurance against liability:

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

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

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

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

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

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

[~~(109)~~] (110) (a) "License" means authorization issued by the commissioner to engage in an activity that is part of or related to the insurance business.

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

[~~(110)~~] (111) (a) "Life insurance" means:

(i) insurance on a human life; and

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

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

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

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

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

[~~(111)~~] (112) "Limited license" means a license that:

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

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

[~~(112)~~] (113) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

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

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

[~~(113)~~] (114) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to an individual through a master, corporate, group, or individual policy.

[~~(114)~~] (115) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

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

[~~(115)~~] (116) "Limited lines authority" includes the lines of insurance listed in Subsection [~~(114)~~] (115).

[~~(116)~~] (117) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

[~~(117)~~] (118) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(117)~~] (118)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; [~~or~~]

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

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

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement[~~.~~]; or

(xi) limited long-term care as defined in Section 31A-22-2002.

[~~(118)~~] (119) "Managed care organization" means a person:

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

(b) (i) licensed under:

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

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

(C) Chapter 14, Foreign Insurers; and

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

[~~(119)~~] (120) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

[~~(120)~~] (121) "Member" means a person having membership rights in an insurance corporation.

[~~(121)~~] (122) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(122)~~] (123) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor has a disability.

[~~(123)~~] (124) "Mortgage guaranty insurance" means surety insurance under which a mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

[~~(124)~~] (125) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

[~~(125)~~] (126) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections [~~(125)~~] (126)(b)(iii)(A) through (D); or

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

[~~(126)~~] (127) "Mutual" means a mutual insurance corporation.

(128) "NAIC" means the National Association of Insurance Commissioners.

(129) "NAIC liquidity stress test framework" means a NAIC publication that includes:

(a) a history of the NAIC's development of regulatory liquidity stress testing;

(b) the scope criteria applicable for a specific data year; and

(c) the liquidity stress test instructions and reporting templates for a specific data year, as adopted by the NAIC and as amended by the NAIC in accordance with NAIC procedures.

[~~(127)~~] (130) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

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

[~~(128)~~] (131) "Network provider" means a health care provider who has an agreement

with a managed care organization to provide health care services to an enrollee with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly from the managed care organization.

[~~(129)~~] (132) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive a dividend representing a share of the surplus of the insurer.

[~~(130)~~] (133) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

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

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

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

[~~(131)~~] (134) "Order" means an order of the commissioner.

[~~(132)~~] (135) "ORSA guidance manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners and as amended from time to time.

[~~(133)~~] (136) "ORSA summary report" means a confidential high-level summary of an insurer or insurance group's own risk and solvency assessment.

[~~(134)~~] (137) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(135)~~] (138) "Own risk and solvency assessment" means an insurer or insurance group's confidential internal assessment:

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

(ii) of the insurer or insurance group's current business plan to support each risk described in Subsection [~~(135)~~] (138)(a)(i); and

(iii) of the sufficiency of capital resources to support each risk described in Subsection [~~(135)~~] (138)(a)(i); and

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

group.

[~~(136)~~] (139) "Participating" means a plan of insurance under which the insured is entitled to receive a dividend representing a share of the surplus of the insurer.

[~~(137)~~] (140) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

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

(b) receives:

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

(ii) another government health benefit.

[~~(138)~~] (141) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

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

[~~(139)~~] (142) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

[~~(140)~~] (143) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec. 1002(16)(B).

[~~(141)~~] (144) "Plan year" means:

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection [~~(141)~~] (144)(a) or (b), the calendar year.

[~~(142)~~] (145) (a) "Policy" means a document, including an attached endorsement or application that:

(i) purports to be an enforceable contract; and

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

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

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

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

(iii) a corporation licensed under:

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

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

(c) "Policy" does not include:

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

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

[~~(143)~~] (146) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(144)~~] (147) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy offering life insurance over a period of years.

[~~(145)~~] (148) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(146)~~] (149) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal regulations and guidance.

[~~(147)~~] (150) "Preexisting condition," with respect to health care insurance:

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

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

[~~(148)~~] (151) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

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

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

[~~(149)~~] (152) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(150)~~] (153) "Proceeding" includes an action or special statutory proceeding.

[~~(151)~~] (154) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

[~~(152)~~] (155) (a) [~~Except as provided in Subsection (152)(b), "property~~] "Property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

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

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

[~~(153)~~] (156) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(154)~~] (157) "Qualified United States financial institution" means an institution that:

(a) is:

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

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

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

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

(i) the commissioner by rule; or

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

[~~(155)~~] (158) (a) "Rate" means:

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(156)~~] (159) (a) [~~Except as provided in Subsection (156)(b), "rate~~] "Rate service organization" means a person who assists an insurer in rate making or filing by:

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

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

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

(b) "Rate service organization" does not [~~mean~~] include:

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

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

[~~(157)~~] (160) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

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

[~~(158)~~] (161) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow, or give, directly or indirectly:

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

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

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

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

(b) "Rebate" does not include:

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

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

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

[~~(159)~~] (162) "Received by the department" means:

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

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

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

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

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

[~~(160)~~] (163) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

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

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

[~~(161)~~] (164) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(162)~~] (165) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(163)~~] (166) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(164)~~] (167) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

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

[~~(165)~~] (168) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

(169) "Scope criteria" means the designated exposure bases and minimum magnitudes for a specified data year that are used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year.

[~~(166)~~] (170) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

[~~(167)~~] (171) (a) "Security" means a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(167)~~] (171)(a)(i) through (xiv); or

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

(b) "Security" does not include:

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

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

[~~(168)~~] (172) "Securityholder" means a specified person who owns a security of a person, including:

(a) common stock;

(b) preferred stock;

(c) debt obligations; and

(d) any other security convertible into or evidencing the right of any of the items listed in this Subsection [~~(168)~~] (172).

[~~(169)~~] (173) (a) "Self-insurance" means an arrangement under which a person provides for spreading [~~its own~~] the person's own risks by a systematic plan.

(b) "Self-insurance" includes:

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

(ii) an arrangement under which a person with a managed program of self-insurance and risk management undertakes to indemnify the person's affiliate, subsidiary, director, officer, or employee for liability or risk that arises out of the person's relationship with the affiliate, subsidiary, director, officer, or employee.

[~~(b) Except as provided in this Subsection (169), "self-insurance"~~] (c) "Self-insurance" does not include:

(i) an arrangement under which a number of persons spread their risks among themselves[~~.~~]; or

(ii) an arrangement with an independent contractor.

[~~(c) "Self-insurance" includes:~~]

[~~(i) an arrangement by which a governmental entity undertakes to indemnify an~~

~~employee for liability arising out of the employee's employment; and~~]

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

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

[~~(170)~~] (174) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(171)~~] (175) "Short-term limited duration health insurance" means a health benefit product that:

(a) after taking into account any renewals or extensions, has a total duration of no more than 36 months; and

(b) has an expiration date specified in the contract that is less than 12 months after the original effective date of coverage under the health benefit product.

[~~(172)~~] (176) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.

[~~(173)~~] (177) (a) "Small employer" means, in connection with a health benefit plan and with respect to a calendar year and to a plan year, an employer who:

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

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

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

(iii) for an employer who has common ownership with one or more other employers, is treated as a single employer under 26 U.S.C. Sec. 414(b), (c), (m), or (o).

(b) "Small employer" does not include an owner or a sole proprietor that does not employ at least one employee.

[~~(174)~~] (178) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance

Portability and Accountability Act.

[~~(175)~~] (179) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(176)~~] (180) Subject to Subsection [~~(91)~~] (92)(b), "surety insurance" includes:

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

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(177)~~] (181) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

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

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

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

(c) "Excess surplus" means:

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

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

(I) 2.5; and

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

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

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(178)~~] (182) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

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

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

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

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

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

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

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

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

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

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

(B) Chapter 26, Insurance Adjusters; and

(ii) whose activities are limited to those authorized under the license the person holds

or for which the person is exempt; or

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

(i) that is:

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

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

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

[~~(179)~~] (183) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(180)~~] (184) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

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

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

[~~(181)~~] (185) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

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

[~~(182)~~] (186) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

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

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

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

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

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

[~~(183)~~] (187) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(184)~~] (188) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage [~~under~~] described in Subsection [~~(152)~~] (155).

[~~(185)~~] (189) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

[~~(186)~~] (190) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

[~~(187)~~] (191) "Workers' compensation insurance" means:

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

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

Section 4. Section **31A-2-403** is amended to read:

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

(1) (a) Subject to Subsection (1)(b), there is created within the department the Title and Escrow Commission that is comprised of five members who shall be, in accordance with Title 63G, Chapter 24, Part 2, Vacancies, appointed by the governor with the advice and consent of the Senate as follows:

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

(ii) two members shall:

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

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

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

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

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

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

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

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

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

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

(2) (a) Subject to Subsection (2)(c), a commission member shall comply with the conflict of interest provisions described in Title 63G, Chapter 24, Part 3, Conflicts of Interest, and file with the commissioner a disclosure of any position of employment or ownership interest that the commission member has with respect to a person that is subject to the jurisdiction of the commissioner.

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

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

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

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

(3) (a) Except as required by Subsection (3)(b), as terms of current commission

members expire, the governor shall appoint each new commission member to a four-year term ending on June 30.

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

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

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

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

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

(a) Section 63A-3-106;

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

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

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

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

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

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

(B) A commission member may, after providing advance notice to the commissioner,

attend an in-person meeting through electronic means.

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

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

(c) The commissioner may call additional meetings:

(i) at the commissioner's discretion;

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

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

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

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

(7) The commissioner shall staff the commission.

Section 5. Section **31A-6a-104** is amended to read:

31A-6a-104. Required disclosures.

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

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

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

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

(i) "Obligations of the provider under this service contract are guaranteed under a

service contract reimbursement insurance policy. Should the provider fail to pay or provide service on any claim within 60 days after proof of loss has been filed, the contract holder is entitled to make a claim directly against the Insurance Company.";

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

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

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

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

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

(iii) as applicable:

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

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

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

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

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

(ii) (A) identify the service contract provider, the seller, and the service contract holder; or

(B) identify the warrantor, the seller, and the warranty holder;

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

(iv) conspicuously state the existence of any deductible amount or service fee;

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

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

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

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

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

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

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

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

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

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

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

(i) a home warranty service contract; or

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

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

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

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

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

(A) immediately below the printed disclosure; and

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

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

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

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

Section 6. Section **31A-16-105** is amended to read:

31A-16-105. Registration of insurers.

(1) (a) An insurer that is authorized to do business in this state and that is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile, if the requirements and standards are substantially similar to those contained in this section, Subsections 31A-16-106(1)(a) and (2) and either Subsection 31A-16-106(1)(b) or a statutory provision similar to the following: "Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition."

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

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

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

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

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

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

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

(iii) transactions not in the ordinary course of business;

(iv) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) all management agreements, service contracts, and all cost-sharing arrangements;

(vi) reinsurance agreements;

(vii) dividends and other distributions to shareholders; and

(viii) consolidated tax allocation agreements;

(d) any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(e) if requested by the commissioner, financial statements of or within an insurance

holding company system, including all affiliates:

(i) which may include annual audited financial statements filed with the United States Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended; and

(ii) which request is satisfied by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the United States Securities and Exchange Commission;

(f) any other matters concerning transactions between registered insurers and any affiliates as may be included in any subsequent registration forms adopted or approved by the commissioner;

(g) statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(h) any other information required by rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

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

(4) (a) No information need be disclosed on the registration statement filed pursuant to Subsection (2) if the information is not material for the purposes of this section.

(b) Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of 1%, or less, of an insurer's admitted assets as of the next preceding December 31 may not be considered material for purposes of [~~this section~~] Subsection (2).

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

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

(7) The commissioner shall terminate the registration of any insurer which

demonstrates that it no longer is a member of an insurance holding company system.

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

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

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

(11) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer, or a disclaimer of affiliation may be filed by any insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation is considered to have been granted unless the commissioner, within 30 days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. If disallowed, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer is granted by the commissioner, or if the disclaimer is considered to have been approved.

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

(13) (a) The ultimate controlling person of an insurer subject to registration shall concurrently file with the registration an annual group capital calculation report as directed by the lead state commissioner.

(b) The annual group capital calculation report described in Subsection (13)(a) shall be filed with the lead state commissioner of the insurance holding company system as determined

by the commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC.

(c) Subject to Subsections (13)(d) and (e), the following insurance holding company systems are exempt from filing the annual group capital calculation report described in Subsection (13)(a):

(i) an insurance holding company system that:

(A) has only one insurer within the insurance holding company's structure;

(B) writes business and is licensed only in the insurance holding company system's domestic state; and

(C) assumes no business from any other insurer;

(ii) an insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board unless:

(A) the lead state commissioner requests the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect; and

(B) the Federal Reserve Board cannot share the calculation with the lead state commissioner;

(iii) an insurance holding company system whose non-United States group-wide supervisor is located within a reciprocal jurisdiction as described in Subsection 31A-17-404(8) that recognizes the United States' state regulatory approach to group supervision and group capital; and

(iv) an insurance holding company system:

(A) that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined the information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook; and

(B) whose non-United States group-wide supervisor that is not located in a reciprocal jurisdiction recognizes and accepts, as specified by the lead state commissioner in regulation, the group capital calculation as the world-wide group capital assessment for United States insurance groups that operate in that jurisdiction.

(d) If, after consultation with other supervisors or officials, the lead state commissioner

determines appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace, the lead state commissioner shall require the group capital calculation for United States operations of any non-United States based insurance holding company system.

(e) The lead state commissioner may:

(i) exempt the ultimate controlling person from filing the annual group capital calculation; or

(ii) accept a limited group capital filing or report in accordance with criteria as specified by the lead state commissioner in regulation.

(f) If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group capital calculation at the next annual filing date unless the lead state commissioner gives an extension based on reasonable grounds.

(14) (a) The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC liquidity stress test framework shall file the results of a specific year's liquidity stress test.

(b) The filing described in Subsection (14)(a) shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC.

(c) Any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured shall be effective on January 1 of the year following the calendar year in which the change is adopted.

(d) Insurers meeting at least one threshold of the NAIC liquidity stress test framework's scope criteria are scoped into the NAIC liquidity stress test framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, determines the insurer should not be scoped into the NAIC liquidity stress test framework for that data year.

(e) Insurers that do not meet at least one threshold of the NAIC liquidity stress test framework's scope criteria are scoped out of the NAIC liquidity stress test framework for the specified data year, unless the lead state insurance commissioner, in consultation with the

NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, determines the insurer should be scoped into the NAIC liquidity stress test framework for that data year.

(f) To avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis, the lead state insurance commissioner, in consultation with the Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, shall assess this concern as part of the lead state insurance commissioner's determination of whether an insurer is scoped into the NAIC liquidity stress test framework for a specified data year.

(g) The performance of, and filing of the results from, a specific year's liquidity stress test shall comply with:

(i) the NAIC liquidity stress test framework instructions and reporting templates for that year; and

(ii) lead state insurance commissioner determinations made in conjunction with the NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, provided within the NAIC liquidity stress test framework.

[~~(13)~~] (15) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for the filing is a violation of this section.

Section 7. Section **31A-16-106** is amended to read:

31A-16-106. Standards and management of an insurer within a holding company system.

(1) (a) Transactions within an insurance holding company system to which an insurer subject to registration is a party are subject to the following standards:

(i) the terms shall be fair and reasonable;

(ii) agreements for cost sharing services and management shall include the provisions required by rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(iii) charges or fees for services performed shall be reasonable;

(iv) expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(v) the books, accounts, and records of each party to all transactions shall be so

maintained as to clearly and accurately disclose the nature and details of the transactions, including the accounting information necessary to support the reasonableness of the charges or fees to the respective parties; [~~and~~]

(vi) the insurer's surplus held for policyholders, following any dividends or distributions to shareholder affiliates, shall be reasonable in relation to the insurer's outstanding liabilities and shall be adequate to its financial needs[~~.~~];

(vii) the commissioner may require the insurer to secure and maintain a deposit held by the commissioner or a bond, as determined by the insurer at the insurer's discretion, in an amount determined by the commissioner not to exceed the value of the agreement in any one year, if the commissioner:

(A) determines that the insurer is in a hazardous financial condition under Title 31A, Chapter 27a, Insurer Receivership Act, or a condition that would warrant a delinquency proceeding under Title 31A, Chapter 27a, Insurer Receivership Act; and

(B) believes that the insurers' affiliate may be unable to fulfill an agreement with the insurer if the insurer were put into liquidation;

(viii) all insurer records and data held by an affiliate:

(A) are the insurer's property;

(B) are subject to the insurer's control;

(C) are identifiable;

(D) are segregated or readily capable of segregation, at no additional cost to the insurer, from all other records and data;

(E) shall be provided to a receiver, at the insurer's request, including any information, software, licensing agreement, release, waiver, or any other thing required to access the records and data; and

(F) may be restricted in use by the affiliate if the affiliate is not operating the insurer's business; and

(ix) (A) all funds belonging to the insurer that an affiliate collects or holds are the exclusive property of the insurer and subject to the control of the insurer; and

(B) if the insurer is placed into receivership, any right of offset against the funds is subject to Title 31A, Chapter 27a, Insurance Receivership Act.

(b) The following transactions involving a domestic insurer and any person in its

insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in Subsections (1)(a)(i) through (vi), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least 30 days before entering into the transaction, or within any shorter period the commissioner may permit, if the commissioner has not disapproved the transaction within the period. The notice for an amendment or modification shall include the reasons for the change and financial impact on the domestic insurer. Informal notice shall be reported, within 30 days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any:

(i) sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments if the transactions are equal to, or exceed as of the next preceding December 31:

(A) for nonlife insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus held for policyholders;

(B) for life insurers, 3% of the insurer's admitted assets;

(ii) loans or extensions of credit made to any person who is not an affiliate, if the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit if the transactions are equal to, or exceed as of the next preceding December 31:

(A) for nonlife insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus held for policyholders;

(B) for life insurers, 3% of the insurer's admitted assets;

(iii) reinsurance agreements or modifications to reinsurance agreements, including an agreement in which the reinsurance premium, a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the current and succeeding three years, equals or exceeds 5% of the insurer's surplus held for policyholders, as of the next preceding December 31, including those agreements that may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and the non-affiliate that any portion of the assets will

be transferred to one or more affiliates of the reinsurer;

(iv) all management agreements, service contracts, tax allocation agreements, and all cost-sharing arrangements;

(v) guarantees when made by a domestic insurer, except that:

(A) a guarantee that is quantifiable as to amount is not subject to the notice requirements of this Subsection (1) unless it exceeds the lesser of .5% of the insurer's admitted assets or 10% of surplus held for policyholders, as of the next preceding December 31; and

(B) a guarantee that is not quantifiable as to amount is subject to the notice requirements of this Subsection (1);

(vi) direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in the investments, exceeds 2.5% of the insurer's surplus to policyholders, except that a direct or indirect acquisition or investment in a subsidiary acquired pursuant to Section 31A-16-102.5, or in a non-subsidiary insurance affiliate that is subject to this chapter, is exempt from this Subsection (1)(b)(vi);

(vii) any material transactions, specified by rule, which the commissioner determines may adversely affect the interests of the insurer's policyholders; and

(viii) this Subsection (1) may not be interpreted to authorize or permit any transactions which would be otherwise contrary to law in the case of an insurer not a member of the same holding company system.

(c) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the holding company system if the purpose of the separate transactions is to avoid the statutory threshold amount and thus to avoid the review by the commissioner that would occur otherwise. If the commissioner determines that the separate transactions were entered into over any 12 month period for such a purpose, the commissioner may exercise the commissioner's authority under Section 31A-16-110.

(d) The commissioner, in reviewing transactions pursuant to Subsection (1)(b), shall consider whether the transactions comply with the standards set forth in Subsection (1)(a) and whether they may adversely affect the interests of policyholders.

(e) The commissioner shall be notified within 30 days of any investment of the domestic insurer in any one corporation, if the total investment in the corporation by the

insurance holding company system exceeds 10% of the corporation's voting securities.

(2) (a) A domestic insurer may not pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(i) 30 days after the commissioner has received notice of the declaration of the dividend and has not within the 30-day period disapproved the payment; or

(ii) the commissioner has approved the payment within the 30-day period.

(b) For purposes of this Subsection (2), an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, fair market value of which, together with that of other dividends or distributions made within the preceding 12 months, exceeds the lesser of:

(i) 10% of the insurer's surplus held for policyholders as of the next preceding December 31;

(ii) the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending the next preceding December 31; or

(iii) an extraordinary dividend does not include pro rata distributions of any class of the insurer's own securities.

(c) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(d) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution, which is conditioned upon the commissioner's approval of the dividend or distribution, and the declaration shall confer no rights upon shareholders until:

(i) the commissioner has approved the payment of the dividend or distribution; or

(ii) the commissioner has not disapproved the payment within the 30-day period referred to in Subsection (2)(a).

(3) (a) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer may not be relieved of any obligation or liability to which they

would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this chapter.

(b) Nothing in this section precludes a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property, or services with one or more other persons under arrangements meeting the standards of Subsection (1)(a).

(c) (i) Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of a domestic insurer, shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity.

(ii) At least one person described in Subsection (3)(c)(i) shall be included in a quorum for the transaction of business at a meeting of the board of directors or a committee of the board of directors.

(d) Subsection (3)(c) does not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees of the board of directors that meet the requirements of Subsection (3)(c) with respect to the controlling entity.

(e) An insurer may make application to the commissioner for a waiver from the requirements of this Subsection (3) if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than $300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this Subsection (3) based upon unique circumstances. The commissioner may consider various factors, including:

(i) the type of business entity;

(ii) the volume of business written;

(iii) the availability of qualified board members; or

(iv) the ownership or organizational structure of the entity.

(4) (a) For purposes of this chapter, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

(i) the size of the insurer as measured by its assets, capital and surplus, reserves,

premium writings, insurance in force, and other appropriate criteria;

(ii) the extent to which the insurer's business is diversified among several lines of insurance;

(iii) the number and size of risks insured in each line of business;

(iv) the extent of the geographical dispersion of the insurer's insured risks;

(v) the nature and extent of the insurer's reinsurance program;

(vi) the quality, diversification, and liquidity of the insurer's investment portfolio;

(vii) the recent past and projected future trend in the size of the insurer's investment portfolio;

(viii) the surplus as regards policyholders maintained by other comparable insurers;

(ix) the adequacy of the insurer's reserves; and

(x) the quality and liquidity of investments in affiliates.

(b) The commissioner may treat an investment described in Subsection (4)(a)(x) as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.

Section 8. Section **31A-16-109** is amended to read:

31A-16-109. Confidentiality of information obtained by commissioner.

(1) (a) Documents, materials, or information obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made under Section 31A-16-107.5, and all information reported or provided to the department under Section 31A-16-105 or 31A-16-108.6, is confidential.

(b) Any confidential document, material, or information described in Subsection (1)(a) is not subject to subpoena and may not be made public by the commissioner or any other person without the permission of the insurer, except the confidential document, material, or information may be provided to the insurance departments of other states, without the prior written consent of the insurer to which the confidential document, material, or information pertains.

(c) The commissioner shall maintain the confidentiality of the following received in accordance with Section 31A-16-105 from an insurance holding company supervised by the Federal Reserve Board or any United States group-wide supervisor:

(i) a group capital calculation;

(ii) a group capital ratio produced within the group capital calculation; or

(iii) group capital information.

(d) The commissioner shall maintain the confidentiality of the liquidity stress test results, supporting disclosures, and any liquidity stress test information received in accordance with Section 31A-16-105 from an insurance holding company supervised by the Federal Reserve Board and non-United States group-wide supervisors.

(2) The commissioner and any person who receives documents, materials, or other information while acting under the authority of the commissioner or with whom the documents, materials, or other information are shared pursuant to this chapter shall keep confidential any confidential documents, materials, or information subject to Subsection (1).

(3) [~~(a)~~] To assist in the performance of the commissioner's duties, the commissioner:

[~~(i)~~] (a) may share documents, materials, proprietary and trade secret documents, or other information, including the confidential documents, materials, or information subject to Subsection (1), with the following if the recipient agrees in writing to maintain the confidentiality status of the document, material, or other information, and has verified in writing the legal authority to maintain confidentiality:

[~~(A)~~] (i) a state, federal, or international regulatory agency;

[~~(B)~~] (ii) the [~~National Association of Insurance Commissioners or an NAIC affiliate or subsidiary; or~~] NAIC;

(iii) a third-party consultant designated by the commissioner; or

[~~(C)~~] (iv) a state, federal, or international law enforcement authority, including a member of a supervisory college described in Section 31A-16-108.5;

[~~(ii)~~] (b) notwithstanding Subsection (1), may only share confidential documents, material, or information reported pursuant to Section 31A-16-105 or 31A-16-108.6 with a commissioner of a state having statutes or regulations substantially similar to Subsection (1) and who has agreed in writing not to disclose the documents, material, or information;

[~~(iii)~~] (c) may receive documents, materials, proprietary and trade secret information, or other information, including otherwise confidential documents, materials, or information from:

[~~(A)~~] (i) the [~~National Association of Insurance Commissioners~~] NAIC or an NAIC affiliate or subsidiary; or

[~~(B)~~] (ii) a regulatory or law enforcement official of a foreign or domestic jurisdiction;

[~~(iv)~~] (d) shall maintain as confidential any document, material, or information received under this section with notice or the understanding that it is confidential under the laws of the jurisdiction that is the source of the document, material, or information; and

[~~(v)~~] (e) shall enter into written agreements with the [~~National Association of Insurance Commissioners~~] NAIC or a third-party consultant designated by the commissioner governing sharing and use of information provided pursuant to this chapter consistent with this Subsection (3) that shall:

[~~(A)~~] (i) specify procedures and protocols regarding the confidentiality and security of information shared with the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries pursuant to this chapter, including procedures and protocols for sharing by the [~~National Association of Insurance Commissioners~~] NAIC with other state, federal, or international regulators;

[~~(B)~~] (ii) specify that ownership of information shared with the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries pursuant to this chapter remains with the commissioner and the [~~National Association of Insurance Commissioner's~~] NAIC's use of the information is subject to the direction of the commissioner;

[~~(C)~~] (iii) require prompt notice to be given to an insurer whose confidential information in the possession of the [~~National Association of Insurance Commissioners~~] NAIC pursuant to this chapter is subject to a request or subpoena to the [~~National Association of Insurance Commissioners~~] NAIC for disclosure or production; and

[~~(D)~~] (iv) require the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries pursuant to this chapter.

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

(5) A waiver of any applicable claim of confidentiality in the documents, materials, or

information does not occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection (3).

(6) Documents, materials, or other information in the possession or control of the [~~National Association of Insurance Commissioners~~] NAIC pursuant to this chapter are:

(a) confidential, not public records, and not open to public inspection; and

(b) not subject to Title 63G, Chapter 2, Government Records Access and Management Act.

Section 9. Section **31A-17-408** is amended to read:

31A-17-408. Title insurance reserves.

(1) In addition to an adequate reserve for outstanding losses, a title insurance company shall either:

(a) maintain and segregate an unearned premium reserve fund of not less than 10 cents for each $1,000 face amount of retained liability under each title insurance contract or policy on a single insurance risk issued; or

(b) have the commissioner review and approve a contract of reinsurance applicable to the title insurance company's policies, which contract adequately covers the exposure or risk which the unearned premium reserve would serve.

(2) The fund shall be maintained for the protection of policyholders and is not subject to the claims of stockholders or creditors other than policyholders.

(3) The title insurance company may release the fund in accordance with the standards of the NAIC Accounting Practices and Procedures Manual.

Section 10. Section **31A-17-601** is amended to read:

31A-17-601. Definitions.

As used in this part:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with Subsection 31A-17-602(5).

(2) "Corrective order" means an order issued by the commissioner specifying corrective action that the commissioner determines is required.

(3) "Health organization" means:

(a) an entity that is authorized under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) that is:

(i) a health maintenance organization;

(ii) a limited health service organization;

(iii) a dental or vision plan;

(iv) a hospital, medical, and dental indemnity or service corporation; or

(v) other managed care organization.

(4) "Life or accident and health insurer" means:

(a) an insurance company licensed to write life insurance, [~~disability~~] accident and health insurance, or both; or

(b) a licensed property casualty insurer writing only disability insurance.

(5) "Property and casualty insurer" means any insurance company licensed to write lines of insurance other than life but does not include a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer.

(6) "RBC" means risk-based capital.

(7) "RBC instructions" means the RBC report including the National Association of Insurance Commissioner's risk-based capital instructions that govern the year for which an RBC report is prepared.

(8) "RBC level" means an insurer's or health organization's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC.

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "Company action level RBC" means the product of 2.0 and its authorized control level RBC;

(c) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC; and

(d) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(9) (a) "RBC plan" means a comprehensive financial plan containing the elements specified in Subsection 31A-17-603(2).

(b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:

(i) the commissioner rejects the RBC plan; and

(ii) the plan is revised by the insurer or health organization, with or without the commissioner's recommendation.

(10) "RBC report" means the report required in Section 31A-17-602.

Section 11. Section **31A-19a-209** is amended to read:

31A-19a-209. Special provisions for title insurance.

(1) (a) (i) The Title and Escrow Commission [~~shall~~] may adopt rules subject to Section 31A-2-404, establishing rate standards and rating methods [~~for individual title insurance producers and agency title insurance producers~~].

(ii) The commissioner shall determine compliance with rate standards and rating methods [~~for title insurers, individual title insurance producers, and agency title insurance producers~~].

(b) In addition to the considerations in determining compliance with rate standards and rating methods as set forth in Sections 31A-19a-201 and 31A-19a-202, including for title insurers, the commissioner and the Title and Escrow Commission shall consider the costs and expenses incurred by title insurers, individual title insurance producers, and agency title insurance producers peculiar to the business of title insurance including:

(i) the maintenance of title plants; and

(ii) the examining of public records to determine insurability of title to real redevelopment property.

(2) (a) [~~A~~] Except as provided in Subsection (2)(b), beginning in 2022, a title insurer, an agency title insurance producer, or an individual title insurance producer who is not an employee of a title insurer or who is not designated by an agency title insurance producer shall annually file with the[~~commissioner.~~] annual report required by Section 31A-23a-413 a certified statement of the following for residential transactions involving a dwelling, as defined in Section 57-21-2, for the prior calendar year:

(i) the average escrow fee the filer charged on the buyer's side; and

(ii) the average escrow fee the filer charged on the seller's side.

(b) In 2022, a filer shall file the certified statement described in Subsection (2)(a) on or before July 1.

(c) In calculating the average residential escrow fees under Subsection (2)(a), the filer

shall:

(i) include the sum of the fees charged for conducting escrow services; and

(ii) exclude any pass-through cost incurred incident to the escrow services or the issuance of the title insurance and separately charged to the consumer.

(d) Each year the commissioner shall:

(i) calculate:

(A) the average escrow fee reported under Subsection (2)(a)(i); and

(B) the average escrow fee reported under Subsection (2)(a)(ii); and

(ii) establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(A) the industry average buyer's side escrow fee as equal to the amount calculated under Subsection (2)(d)(i)(A); and

(B) the industry average seller's side escrow fee as equal to the amount calculated under Subsection (2)(d)(i)(B).

(e) The rule described in Subsection (2)(d) shall take effect on January 1 of the following calendar year.

(3) A title insurer, an agency title insurance producer, or an individual title insurance producer may not charge for escrow services an amount less than 50% of the applicable industry average escrow fee described in Subsection (2)(d).

[~~(i) a schedule of the escrow charges that the title insurer, individual title insurance producer, or agency title insurance producer proposes to use in this state for services performed in connection with the issuance of policies of title insurance; and~~]

[~~(ii) any changes to the schedule of the escrow charges described in Subsection (2)(a)(i).~~]

[~~(b) Except for a schedule filed by a title insurer under this Subsection (2), a schedule filed under this Subsection (2) is subject to review by the Title and Escrow Commission.~~]

[~~(c) (i) The schedule of escrow charges required to be filed by Subsection (2)(a)(i) takes effect on the day on which the schedule of escrow charges is filed.~~]

[~~(ii) Any changes to the schedule of the escrow charges required to be filed by Subsection (2)(a)(ii) take effect on the day specified in the change to the schedule of escrow charges except that the effective date may not be less than 30 calendar days after the day on~~

~~which the change to the schedule of escrow charges is filed.~~]

[~~(3) A title insurer, individual title insurance producer, or agency title insurance producer may not file or use any rate or other charge relating to the business of title insurance, including rates or charges filed for escrow that would cause the title insurance company, individual title insurance producer, or agency title insurance producer to:~~]

[~~(a) operate at less than the cost of doing:~~]

[~~(i) the insurance business; or~~]

[~~(ii) the escrow business; or~~]

[~~(b) fail to adequately underwrite a title insurance policy.~~]

[~~(4) (a) All or any of the schedule of rates or schedule of charges, including the schedule of escrow charges, may be changed or amended at any time, subject to the limitations in this Subsection (4).~~]

[~~(b) Each change or amendment shall:~~]

[~~(i) be filed with the commissioner, subject to review by the Title and Escrow Commission; and~~]

[~~(ii) state the effective date of the change or amendment, which may not be less than 30 calendar days after the day on which the change or amendment is filed.~~]

[~~(c) Any change or amendment remains in force for a period of at least 90 calendar days from the change or amendment's effective date.~~]

[~~(5) While the schedule of rates and schedule of charges are effective, a copy of each shall be:~~]

[~~(a) retained in each of the offices of:~~]

[~~(i) the title insurer in this state;~~]

[~~(ii) the title insurer's individual title insurance producers or agency title insurance producers in this state; and~~]

[~~(b) upon request, furnished to the public.~~]

[~~(6) Except in accordance with the schedules of rates and charges filed with the commissioner, a title insurer, individual title insurance producer, or agency title insurance producer may not make or impose any premium or other charge:~~]

[~~(a) in connection with the issuance of a policy of title insurance; or~~]

[~~(b) for escrow services performed in connection with the issuance of a policy of title~~

~~insurance.~~]

Section 12. Section **31A-21-201** is amended to read:

31A-21-201. Filing of forms.

(1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may not be used, sold, or offered for sale until the form is filed with the commissioner.

(b) A form is considered filed with the commissioner when the commissioner receives:

(i) the form;

(ii) the applicable filing fee as prescribed under Section 31A-3-103; and

(iii) the applicable transmittal forms as required by the commissioner.

(2) In filing a form for use in this state the insurer is responsible for assuring that the form is in compliance with this title and rules adopted by the commissioner.

(3) (a) The commissioner may prohibit the use of a form at any time upon a finding that:

(i) the form:

(A) is inequitable;

(B) is unfairly discriminatory;

(C) is misleading;

(D) is deceptive;

(E) is obscure;

(F) is unfair;

(G) encourages misrepresentation; or

(H) is not in the public interest;

(ii) the form provides benefits or contains another provision that endangers the solidity of the insurer;

(iii) except for a life or accident and health insurance policy form, the form is an insurance policy or application for an insurance policy, that fails to conspicuously provide:

(A) the exact name of the insurer; and

(B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy;

(iv) except an application required by Section 31A-22-635, the form is a life or accident and health insurance [~~policy~~] form that fails to conspicuously provide:

(A) the exact name of the insurer;

(B) the state of domicile of the insurer [~~filing the insurance policy or application for the insurance policy~~]; and

(C) for a life insurance policy only, the address of the administrative office of the insurer filing the form;

(v) the form violates a statute or a rule adopted by the commissioner; or

(vi) the form is otherwise contrary to law.

(b) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the day on which the commissioner issues the order, the use of the form be discontinued.

(ii) Once use of a form is prohibited, the form may not be used until appropriate changes are filed with and reviewed by the commissioner.

(iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to the existing policyholders.

(c) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:

(i) be in writing;

(ii) constitute an order; and

(iii) state the reasons for the prohibition.

(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that a form be subject to the commissioner's approval before an insurer uses the form.

(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for a form if the procedures are different from the procedures stated in this section.

(c) The type of form that under Subsection (4)(a) the commissioner may require approval of before use includes:

(i) a form for a particular class of insurance;

(ii) a form for a specific line of insurance;

(iii) a specific type of form; or

(iv) a form for a specific market segment.

(5) (a) An insurer shall maintain a complete and accurate record of the following for the time period described in Subsection (5)(b):

(i) a form:

(A) filed under this section for use; or

(B) that is in use; and

(ii) a document filed under this section with a form described in Subsection (5)(a)(i).

(b) The insurer shall maintain a record required under Subsection (5)(a) for the balance of the current year, plus five years from:

(i) the last day on which the form is used; or

(ii) the last day an insurance policy that is issued using the form is in effect.

Section 13. Section **31A-21-303** is amended to read:

31A-21-303. Cancellation, issuance, renewal.

(1) (a) Except as otherwise provided in this section, other statutes, or by rule under Subsection (1)(c), this section applies to all policies of insurance:

(i) except for:

(A) life insurance;

(B) accident and health insurance; and

(C) annuities; and

(ii) if the policies of insurance are issued on forms that are subject to filing under Subsection 31A-21-201(1).

(b) A policy may provide terms more favorable to insureds than this section requires.

(c) The commissioner may by rule totally or partially exempt from this section classes of insurance policies in which the insureds do not need protection against arbitrary or unannounced termination.

(d) The rights provided by this section are in addition to and do not prejudice any other rights the insureds may have at common law or under other statutes.

(2) (a) As used in this Subsection (2), "grounds" means:

(i) material misrepresentation;

(ii) substantial change in the risk assumed, unless the insurer should reasonably have foreseen the change or contemplated the risk when entering into the contract;

(iii) substantial breaches of contractual duties, conditions, or warranties;

(iv) attainment of the age specified as the terminal age for coverage, in which case the insurer may cancel by notice under Subsection (2)(c), accompanied by a tender of proportional return of premium; or

(v) in the case of motor vehicle insurance, revocation or suspension of the driver's license of:

(A) the named insured; or

(B) any other person who customarily drives the motor vehicle.

(b) (i) Except as provided in Subsection (2)(e) or unless the conditions of Subsection (2)(b)(ii) are met, an insurance policy may not be canceled by the insurer before the earlier of:

(A) the expiration of the agreed term; or

(B) one year from the effective date of the policy or renewal.

(ii) Notwithstanding Subsection (2)(b)(i), an insurance policy may be canceled by the insurer for:

(A) nonpayment of a premium when due; or

(B) on grounds defined in Subsection (2)(a).

(c) (i) The cancellation provided by Subsection (2)(b), except cancellation for nonpayment of premium, is effective no sooner than 30 days after the delivery or first-class mailing of a written notice to the policyholder.

(ii) Cancellation for nonpayment of premium of a personal lines policy is effective no sooner than 10 days after delivery or first-class mailing of a written notice to the policyholder.

(iii) Cancellation for nonpayment of premium of a commercial lines policy is effective no sooner than 10 days after delivery or first-class mailing of a written notice to:

(A) the policyholder;

(B) each assignee of the policyholder, if the assignee is named in the policy; and

(C) each loss payee or mortgagee or lienholder under property insurance of the policyholder, if the loss payee, mortgagee, or lienholder is named in the policy.

(iv) An insurer shall deliver or send by first-class mail a copy of the notice of cancellation for nonpayment of premium described in Subsection (2)(c)(iii) to an agent of record of the policyholder on or before the day on which the insurer provides the notice to the policyholder.

(d) (i) Notice of cancellation for nonpayment of premium shall include a statement of

the reason for cancellation.

(ii) Subsection (7) applies to the notice required for grounds of cancellation other than nonpayment of premium.

(e) (i) Subsections (2)(a) through (d) do not apply to any insurance contract that has not been previously renewed if the contract has been in effect less than 60 days on the day on which the written notice of cancellation is mailed or delivered.

(ii) A cancellation under this Subsection (2)(e) may not be effective until at least 10 days after the day on which a written notice of cancellation is delivered to the insured.

(iii) If the notice required by this Subsection (2)(e) is sent by first-class mail, postage prepaid, to the insured at the insured's last-known address, delivery is considered accomplished after the passing, since the mailing date, of the mailing time specified in the Utah Rules of Civil Procedure.

(iv) A policy cancellation subject to this Subsection (2)(e) is not subject to the procedures described in Subsection (7).

(3) A policy may be issued for a term longer than one year or for an indefinite term if the policy includes a clause providing for cancellation by the insurer by giving notice as provided in Subsection (4)(b)(i) 30 days before an anniversary date.

(4) (a) Subject to Subsections (2), (3), and (4)(b), a policyholder has a right to have the policy renewed:

(i) on the terms then being applied by the insurer to similar risks; and

(ii) (A) for an additional period of time equivalent to the expiring term if the agreed term is one year or less; or

(B) for one year if the agreed term is longer than one year.

(b) Except as provided in Subsections (4)(c) and (5), the right to renewal under Subsection (4)(a) is extinguished if:

(i) at least 30 days before the day on which the policy expires or completes an anniversary, the insurer delivers or sends by first-class mail a notice of intention not to renew the policy beyond the agreed expiration or anniversary date to the policyholder at the policyholder's last-known address;

(ii) not more than 45 nor less than 14 days before the day on which the renewal premium is due, the insurer delivers or sends by first-class mail a notice to the policyholder at

the policyholder's last-known address, clearly stating:

(A) the renewal premium;

(B) how the renewal premium may be paid, including the due date for payment of the renewal premium;

(C) that failure to pay the renewal premium extinguishes the policyholder's right to renewal; and

(D) subject to Subsection (4)(e), that the extinguishment of the right to renew for nonpayment of premium is effective no sooner than at least 10 days after delivery or first-class mailing of a written notice to the policyholder that the policyholder has failed to pay the premium when due;

(iii) the policyholder has:

(A) accepted replacement coverage; or

(B) requested or agreed to nonrenewal; or

(iv) the policy is expressly designated as nonrenewable.

(c) Unless the conditions of Subsection (4)(b)(iii) or (iv) apply, an insurer may not fail to renew an insurance policy as a result of a telephone call or other inquiry that:

(i) references a policy coverage; and

(ii) does not result in the insured requesting payment of a claim.

(d) Failure to renew under this Subsection (4) is subject to Subsection (5).

(e) (i) (A) If the policy is a personal lines policy, during the period that begins when an insurer delivers or sends by first-class mail the notice described in Subsection (4)(b)(ii)(D) and ends when the premium is paid, coverage exists and premiums are due.

(B) If the policy is a commercial lines policy, during the period that begins when an insurer delivers or sends by first-class mail the notice described in Subsection (2)(c)(iii) and ends when the premium is paid, coverage exists and premiums are due.

(ii) (A) If after receiving the notice required by Subsection (4)(b)(ii)(D) a personal lines policyholder fails to pay the renewal premium, the coverage is extinguished as of the date the renewal premium is originally due.

(B) If after receiving the notice required under Subsection (2)(c)(iii), a commercial lines policyholder fails to pay the renewal premium within the 10 days before the day on which cancellation for nonpayment is effective, the coverage is extinguished as of the day on which

the renewal premium is originally due.

(iii) Delivery of the notice required by Subsection (2)(c)(iii), (2)(c)(iv), or (4)(b)(ii)(D) includes electronic delivery in accordance with Section 31A-21-316.

(iv) An insurer is not subject to Subsection (4)(b)(ii)(D) if:

(A) the insurer provides notice of the extinguishment of the right to renew for failure to pay premium at least 15 days, but no longer than 45 days, before the day on which the renewal payment is due; and

(B) the policy is a personal lines policy.

(v) Subsection (4)(b)(ii)(D) does not apply to a policy that provides coverage for 30 days or less.

(5) Notwithstanding Subsection (4), an insurer may not fail to renew the following personal lines insurance policies solely on the basis of:

(a) in the case of a motor vehicle insurance policy:

(i) a claim from the insured that:

(A) results from an accident in which:

(I) the insured is not at fault; and

(II) the driver of the motor vehicle that is covered by the motor vehicle insurance policy is 21 years of age or older; and

(B) is the only claim meeting the condition of Subsection (5)(a)(i)(A) within a 36-month period;

(ii) a single traffic violation by an insured that:

(A) is a violation of a speed limit under Title 41, Chapter 6a, Traffic Code;

(B) is not in excess of 10 miles per hour over the speed limit;

(C) is not a traffic violation under:

(I) Section 41-6a-601;

(II) Section 41-6a-604; or

(III) Section 41-6a-605;

(D) is not a violation by an insured driver who is younger than 21 years of age; and

(E) is the only violation meeting the conditions of Subsections (5)(a)(ii)(A) through (D) within a 36-month period; or

(iii) a claim for damage that:

(A) results solely from:

(I) wind;

(II) hail;

(III) lightning; or

(IV) an earthquake;

(B) is not preventable by the exercise of reasonable care; and

(C) is the only claim meeting the conditions of Subsections (5)(a)(iii)(A) and (B) within a 36-month period; and

(b) in the case of a homeowner's insurance policy, a claim by the insured that is for damage that:

(i) results solely from:

(A) wind;

(B) hail; or

(C) lightning;

(ii) is not preventable by the exercise of reasonable care; and

(iii) is the only claim meeting the conditions of Subsections (5)(b)(i) and (ii) within a 36-month period.

(6) (a) (i) Subject to Subsection (6)(b), if the insurer offers or purports to renew the policy, but on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date if the insurer delivered or sent by first-class mail to the policyholder notice of the new terms or rates at least 30 days before the day on which the previous policy expires.

(ii) If the insurer did not give the prior notification described in Subsection (6)(a)(i) to the policyholder, the new terms or rates do not take effect until 30 days after the day on which the insurer delivers or sends by first-class mail the notice, in which case the policyholder may elect to cancel the renewal policy at any time during the 30-day period.

(iii) Return premiums or additional premium charges shall be calculated proportionately on the basis that the old rates apply.

(b) Except as provided in Subsection (6)(c), Subsection (6)(a) does not apply if the only change in terms that is adverse to the policyholder is:

(i) a rate increase generally applicable to the class of business to which the policy belongs;

(ii) a rate increase resulting from a classification change based on the altered nature or extent of the risk insured against; or

(iii) a policy form change made to make the form consistent with Utah law.

(c) Subsections (6)(b)(i) and (ii) do not apply to a rate increase of 25% or more on a commercial policy.

(7) (a) If a notice of cancellation or nonrenewal under Subsection (2)(c) does not state with reasonable precision the facts on which the insurer's decision is based, the insurer shall send by first-class mail or deliver that information within 10 working days after receipt of a written request by the policyholder.

(b) A notice under Subsection (2)(c) is not effective unless it contains information about the policyholder's right to make the request.

(8) (a) An insurer that gives a notice of nonrenewal or cancellation of insurance on a motor vehicle insurance policy issued in accordance with the requirements of Chapter 22, Part 3, Motor Vehicle Insurance, for nonpayment of a premium shall provide notice of nonrenewal or cancellation to a lienholder if the insurer has been provided the name and mailing address of the lienholder.

(b) An insurer shall provide the notice described in Subsection (8)(a) to the lienholder by first-class mail or, if agreed by the parties, any electronic means of communication.

(c) A lienholder shall provide a current physical address of notification or an electronic address of notification to an insurer that is required to make a notification under Subsection (8)(a).

(9) If a risk-sharing plan under Section 31A-2-214 exists for the kind of coverage provided by the insurance being cancelled or nonrenewed, a notice of cancellation or nonrenewal required under Subsection (2)(c) or (4)(b)(i) may not be effective unless the notice contains instructions to the policyholder for applying for insurance through the available risk-sharing plan.

(10) There is no liability on the part of, and no cause of action against, any insurer, its authorized representatives, agents, employees, or any other person furnishing to the insurer information relating to the reasons for cancellation or nonrenewal or for any statement made or information given by them in complying or enabling the insurer to comply with this section unless actual malice is proved by clear and convincing evidence.

(11) This section does not alter any common law right of contract rescission for material misrepresentation.

(12) If a person is required to pay a premium in accordance with this section:

(a) the person may make the payment using:

(i) the United States Postal Service;

(ii) a delivery service the commissioner describes or designates by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; or

(iii) electronic means; and

(b) the payment is considered to be made:

(i) for a payment that is mailed using the method described in Subsection (12)(a)(i), on the date on which the payment is postmarked;

(ii) for a payment that is delivered using the method described in Subsection (12)(a)(ii), on the date on which the delivery service records or marks the payment as having been received by the delivery service; or

(iii) for a payment that is made using the method described in Subsection (12)(a)(iii), on the date on which the payment is made electronically.

Section 14. Section **31A-22-305.3** is amended to read:

31A-22-305.3. Underinsured motorist coverage.

(1) As used in this section:

(a) "Covered person" has the same meaning as defined in Section 31A-22-305.

(b) (i) "Underinsured motor vehicle" includes a motor vehicle, the operation, maintenance, or use of which is covered under a liability policy at the time of an injury-causing occurrence, but which has insufficient liability coverage to compensate fully the injured party for all special and general damages.

(ii) The term "underinsured motor vehicle" does not include:

(A) a motor vehicle that is covered under the liability coverage of the same policy that also contains the underinsured motorist coverage;

(B) an uninsured motor vehicle as defined in Subsection 31A-22-305(2);

(C) a motor vehicle owned or leased by:

(I) a named insured;

(II) a named insured's spouse; or

(III) a dependent of a named insured.

(2) (a) Underinsured motorist coverage under Subsection 31A-22-302(1)(c) provides coverage for a covered person who is legally entitled to recover damages from an owner or operator of an underinsured motor vehicle because of bodily injury, sickness, disease, or death.

(b) A covered person occupying or using a motor vehicle owned, leased, or furnished to the covered person, the covered person's spouse, or covered person's resident relative may recover underinsured benefits only if the motor vehicle is:

(i) described in the policy under which a claim is made; or

(ii) a newly acquired or replacement motor vehicle covered under the terms of the policy.

(3) (a) For purposes of this Subsection (3), "new policy" means:

(i) any policy that is issued that does not include a renewal or reinstatement of an existing policy; or

(ii) a change to an existing policy that results in:

(A) a named insured being added to or deleted from the policy; or

(B) a change in the limits of the named insured's motor vehicle liability coverage.

(b) For new policies written on or after January 1, 2001, the limits of underinsured motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy, unless a named insured rejects or purchases coverage in a lesser amount by signing an acknowledgment form that:

(i) is filed with the department;

(ii) is provided by the insurer;

(iii) waives the higher coverage;

(iv) need only state in this or similar language that "underinsured motorist coverage provides benefits or protection to you and other covered persons for bodily injury resulting from an accident caused by the fault of another party where the other party has insufficient liability insurance"; and

(v) discloses the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the

insurer under the named insured's motor vehicle policy.

(c) Any selection or rejection under Subsection (3)(b) continues for that issuer of the liability coverage until the insured requests, in writing, a change of underinsured motorist coverage from that liability insurer.

(d) (i) Subsections (3)(b) and (c) apply retroactively to any claim arising on or after January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsections (3)(b) and (c) clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

(e) (i) As used in this Subsection (3)(e), "additional motor vehicle" means a change that increases the total number of vehicles insured by the policy, and does not include replacement, substitute, or temporary vehicles.

(ii) The adding of an additional motor vehicle to an existing personal lines or commercial lines policy does not constitute a new policy for purposes of Subsection (3)(a).

(iii) If an additional motor vehicle is added to a personal lines policy where underinsured motorist coverage has been rejected, or where underinsured motorist limits are lower than the named insured's motor vehicle liability limits, the insurer shall provide a notice to a named insured within 30 days that:

(A) in the same manner described in Subsection (3)(b)(iv), explains the purpose of underinsured motorist coverage; and

(B) encourages the named insured to contact the insurance company or insurance producer for quotes as to the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(f) A change in policy number resulting from any policy change not identified under Subsection (3)(a)(ii) does not constitute a new policy.

(g) (i) Subsection (3)(a) applies retroactively to any claim arising on or after January 1, 2001 for which, as of May 1, 2012, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsection (3)(a):

(A) does not enlarge, eliminate, or destroy vested rights; and

(B) clarifies legislative intent.

(h) A self-insured, including a governmental entity, may elect to provide underinsured motorist coverage in an amount that is less than its maximum self-insured retention under Subsections (3)(b) and (l) by issuing a declaratory memorandum or policy statement from the chief financial officer or chief risk officer that declares the:

(i) self-insured entity's coverage level; and

(ii) process for filing an underinsured motorist claim.

(i) Underinsured motorist coverage may not be sold with limits that are less than:

(i) $10,000 for one person in any one accident; and

(ii) at least $20,000 for two or more persons in any one accident.

(j) An acknowledgment under Subsection (3)(b) continues for that issuer of the underinsured motorist coverage until the named insured, in writing, requests different underinsured motorist coverage from the insurer.

(k) (i) The named insured's underinsured motorist coverage, as described in Subsection (2), is secondary to the liability coverage of an owner or operator of an underinsured motor vehicle, as described in Subsection (1).

(ii) Underinsured motorist coverage may not be set off against the liability coverage of the owner or operator of an underinsured motor vehicle, but shall be added to, combined with, or stacked upon the liability coverage of the owner or operator of the underinsured motor vehicle to determine the limit of coverage available to the injured person.

(l) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for policies existing on that date, the insurer shall disclose in the same medium as the premium renewal notice, an explanation of:

(A) the purpose of underinsured motorist coverage in the same manner as described in Subsection (3)(b)(iv); and

(B) a disclosure of the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(ii) The disclosure required under this Subsection (3)(l) shall be sent to all named

insureds that carry underinsured motorist coverage limits in an amount less than the named insured's motor vehicle liability policy limits or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(m) For purposes of this Subsection (3), a notice or disclosure sent to a named insured in a household constitutes notice or disclosure to all insureds within the household.

(4) (a) (i) Except as provided in this Subsection (4), a covered person injured in a motor vehicle described in a policy that includes underinsured motorist benefits may not elect to collect underinsured motorist coverage benefits from another motor vehicle insurance policy.

(ii) The limit of liability for underinsured motorist coverage for two or more motor vehicles may not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident.

(iii) Subsection (4)(a)(ii) applies to all persons except a covered person described under Subsections (4)(b)(i) and (ii).

(b) (i) A covered person injured as a pedestrian by an underinsured motor vehicle may recover underinsured motorist benefits under any one other policy in which they are described as a covered person.

(ii) Except as provided in Subsection (4)(b)(iii), a covered person injured while occupying, using, or maintaining a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's spouse, or the covered person's resident parent or resident sibling, may also recover benefits under any one other policy under which the covered person is also a covered person.

(iii) (A) A covered person may recover benefits from no more than two additional policies, one additional policy from each parent's household if the covered person is:

(I) a dependent minor of parents who reside in separate households; and

(II) injured while occupying or using a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's resident parent, or the covered person's resident sibling.

(B) Each parent's policy under this Subsection (4)(b)(iii) is liable only for the percentage of the damages that the limit of liability of each parent's policy of underinsured motorist coverage bears to the total of both parents' underinsured coverage applicable to the accident.

(iv) A covered person's recovery under any available policies may not exceed the full amount of damages.

(v) Underinsured coverage on a motor vehicle occupied at the time of an accident is primary coverage, and the coverage elected by a person described under Subsections 31A-22-305(1)(a), (b), and (c) is secondary coverage.

(vi) The primary and the secondary coverage may not be set off against the other.

(vii) A covered person as described under Subsection (4)(b)(i) or is entitled to the highest limits of underinsured motorist coverage under only one additional policy per household applicable to that covered person as a named insured, spouse, or relative.

(viii) A covered injured person is not barred against making subsequent elections if recovery is unavailable under previous elections.

(ix) (A) As used in this section, "interpolicy stacking" means recovering benefits for a single incident of loss under more than one insurance policy.

(B) Except to the extent permitted by this Subsection (4), interpolicy stacking is prohibited for underinsured motorist coverage.

(c) Underinsured motorist coverage:

(i) does not cover any benefit paid or payable under Title 34A, Chapter 2, Workers' Compensation Act, except that the covered person is credited an amount described in Subsection 34A-2-106(5);

(ii) may not be subrogated by a workers' compensation insurance carrier;

(iii) may not be reduced by benefits provided by workers' compensation insurance;

(iv) may be reduced by health insurance subrogation only after the covered person is made whole;

(v) may not be collected for bodily injury or death sustained by a person:

(A) while committing a violation of Section 41-1a-1314;

(B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated in violation of Section 41-1a-1314; or

(C) while committing a felony; and

(vi) notwithstanding Subsection (4)(c)(v), may be recovered:

(A) for a person [~~under 18 years of age~~] younger than 18 years old who is injured within the scope of Subsection (4)(c)(v), but is limited to medical and funeral expenses; or

(B) by a law enforcement officer as defined in Section 53-13-103, who is injured within the course and scope of the law enforcement officer's duties.

(5) The inception of the loss under Subsection 31A-21-313(1) for underinsured motorist claims occurs upon the date of the last liability policy payment.

(6) An underinsured motorist insurer does not have a right of reimbursement against a person liable for the damages resulting from an injury-causing occurrence if the person's liability insurer has tendered the policy limit and the limits have been accepted by the claimant.

(7) Except as otherwise provided in this section, a covered person may seek, subject to the terms and conditions of the policy, additional coverage under any policy:

(a) that provides coverage for damages resulting from motor vehicle accidents; and

(b) that is not required to conform to Section 31A-22-302.

(8) (a) When a claim is brought by a named insured or a person described in Subsection 31A-22-305(1) and is asserted against the covered person's underinsured motorist carrier, the claimant may elect to resolve the claim:

(i) by submitting the claim to binding arbitration; or

(ii) through litigation.

(b) Unless otherwise provided in the policy under which underinsured benefits are claimed, the election provided in Subsection (8)(a) is available to the claimant only, except that if the policy under which insured benefits are claimed provides that either an insured or the insurer may elect arbitration, the insured or the insurer may elect arbitration and that election to arbitrate shall stay the litigation of the claim under Subsection (8)(a)(ii).

(c) Once a claimant elects to commence litigation under Subsection (8)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the underinsured motorist coverage carrier.

(d) For purposes of the statute of limitations applicable to a claim described in Subsection (8)(a), if the claimant does not elect to resolve the claim through litigation, the claim is considered filed when the claimant submits the claim to binding arbitration in accordance with this Subsection (8).

(e) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (8)(a)(i) shall be resolved by a single arbitrator.

(ii) All parties shall agree on the single arbitrator selected under Subsection (8)(e)(i).

(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (8)(e)(ii), the parties shall select a panel of three arbitrators.

(f) If the parties select a panel of three arbitrators under Subsection (8)(e)(iii):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (8)(f)(i) shall select one additional arbitrator to be included in the panel.

(g) Unless otherwise agreed to in writing:

(i) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(e)(i); or

(ii) if an arbitration panel is selected under Subsection (8)(e)(iii):

(A) each party shall pay the fees and costs of the arbitrator selected by that party; and

(B) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(f)(ii).

(h) Except as otherwise provided in this section or unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section is governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

(i) (i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f), 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of Subsections (9)(a) through (c) are satisfied.

(ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure shall be determined based on the claimant's specific monetary amount in the written demand for payment of uninsured motorist coverage benefits as required in Subsection (9)(a)(i)(A).

(iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to arbitration claims under this part.

(j) An issue of discovery shall be resolved by the arbitrator or the arbitration panel.

(k) A written decision by a single arbitrator or by a majority of the arbitration panel constitutes a final decision.

(l) (i) Except as provided in Subsection (9), the amount of an arbitration award may not exceed the underinsured motorist policy limits of all applicable underinsured motorist policies, including applicable underinsured motorist umbrella policies.

(ii) If the initial arbitration award exceeds the underinsured motorist policy limits of all

applicable underinsured motorist policies, the arbitration award shall be reduced to an amount equal to the combined underinsured motorist policy limits of all applicable underinsured motorist policies.

(m) The arbitrator or arbitration panel may not decide an issue of coverage or extra-contractual damages, including:

(i) whether the claimant is a covered person;

(ii) whether the policy extends coverage to the loss; or

(iii) an allegation or claim asserting consequential damages or bad faith liability.

(n) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(o) If the arbitrator or arbitration panel finds that the arbitration is not brought, pursued, or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees and costs against the party that failed to bring, pursue, or defend the arbitration in good faith.

(p) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (8)(m) between the parties unless:

(i) the award is procured by corruption, fraud, or other undue means; or

(ii) either party, within 20 days after service of the arbitration award:

(A) files a complaint requesting a trial de novo in the district court; and

(B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (8)(p)(ii)(A).

(q) (i) Upon filing a complaint for a trial de novo under Subsection (8)(p), a claim shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of Evidence in the district court.

(ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a complaint requesting a trial de novo under Subsection (8)(p)(ii)(A).

(r) (i) If the claimant, as the moving party in a trial de novo requested under Subsection (8)(p), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

(ii) If the underinsured motorist carrier, as the moving party in a trial de novo requested under Subsection (8)(p), does not obtain a verdict that is at least 20% less than the arbitration award, the underinsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (8)(r)(iv), the costs under this Subsection (8)(r) shall include:

(A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(B) the costs of expert witnesses and depositions.

(iv) An award of costs under this Subsection (8)(r) may not exceed $2,500 unless Subsection (9)(h)(iii) applies.

(s) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (8)(r), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(i) was not fully disclosed in writing prior to the arbitration proceeding; or

(ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(t) If a district court determines, upon a motion of the nonmoving party, that a moving party's use of the trial de novo process is filed in bad faith in accordance with Section 78B-5-825, the district court may award reasonable attorney fees to the nonmoving party.

(u) Nothing in this section is intended to limit a claim under another portion of an applicable insurance policy.

(v) If there are multiple underinsured motorist policies, as set forth in Subsection (4), the claimant may elect to arbitrate in one hearing the claims against all the underinsured motorist carriers.

(9) (a) Within 30 days after a covered person elects to submit a claim for underinsured motorist benefits to binding arbitration or files litigation, the covered person shall provide to the underinsured motorist carrier:

(i) a written demand for payment of underinsured motorist coverage benefits, setting forth:

(A) subject to Subsection (9)(l), the specific monetary amount of the demand, including a computation of the covered person's claimed past medical expenses, claimed past lost wages, and all other claimed past economic damages; and

(B) the factual and legal basis and any supporting documentation for the demand;

(ii) a written statement under oath disclosing:

(A) (I) the names and last known addresses of all health care providers who have

rendered health care services to the covered person that are material to the claims for which the underinsured motorist benefits are sought for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) the names and last known addresses of the health care providers who have rendered health care services to the covered person, which the covered person claims are immaterial to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised that have not been disclosed under Subsection (9)(a)(ii)(A)(I);

(B) (I) the names and last known addresses of all health insurers or other entities to whom the covered person has submitted claims for health care services or benefits material to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) the names and last known addresses of the health insurers or other entities to whom the covered person has submitted claims for health care services or benefits, which the covered person claims are immaterial to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation have not been disclosed;

(C) if lost wages, diminished earning capacity, or similar damages are claimed, all employers of the covered person for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised;

(D) other documents to reasonably support the claims being asserted; and

(E) all state and federal statutory lienholders including a statement as to whether the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens; and

(iii) signed authorizations to allow the underinsured motorist carrier to only obtain

records and billings from the individuals or entities disclosed under Subsections (9)(a)(ii)(A)(I), (B)(I), and (C).

(b) (i) If the underinsured motorist carrier determines that the disclosure of undisclosed health care providers or health care insurers under Subsection (9)(a)(ii) is reasonably necessary, the underinsured motorist carrier may:

(A) make a request for the disclosure of the identity of the health care providers or health care insurers; and

(B) make a request for authorizations to allow the underinsured motorist carrier to only obtain records and billings from the individuals or entities not disclosed.

(ii) If the covered person does not provide the requested information within 10 days:

(A) the covered person shall disclose, in writing, the legal or factual basis for the failure to disclose the health care providers or health care insurers; and

(B) either the covered person or the underinsured motorist carrier may request the arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be provided if the covered person has elected arbitration.

(iii) The time periods imposed by Subsection (9)(c)(i) are tolled pending resolution of the dispute concerning the disclosure and production of records of the health care providers or health care insurers.

(c) (i) An underinsured motorist carrier that receives an election for arbitration or a notice of filing litigation and the demand for payment of underinsured motorist benefits under Subsection (9)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and receipt of the items specified in Subsections (9)(a)(i) through (iii), to:

(A) provide a written response to the written demand for payment provided for in Subsection (9)(a)(i);

(B) except as provided in Subsection (9)(c)(i)(C), tender the amount, if any, of the underinsured motorist carrier's determination of the amount owed to the covered person; and

(C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens, tender the amount, if any, of the underinsured motorist carrier's determination of the amount owed to the covered person less:

(I) if the amount of the state or federal statutory lien is established, the amount of the lien; or

(II) if the amount of the state or federal statutory lien is not established, two times the amount of the medical expenses subject to the state or federal statutory lien until such time as the amount of the state or federal statutory lien is established.

(ii) If the amount tendered by the underinsured motorist carrier under Subsection (9)(c)(i) is the total amount of the underinsured motorist policy limits, the tendered amount shall be accepted by the covered person.

(d) A covered person who receives a written response from an underinsured motorist carrier as provided for in Subsection (9)(c)(i), may:

(i) elect to accept the amount tendered in Subsection (9)(c)(i) as payment in full of all underinsured motorist claims; or

(ii) elect to:

(A) accept the amount tendered in Subsection (9)(c)(i) as partial payment of all underinsured motorist claims; and

(B) continue to litigate or arbitrate the remaining claim in accordance with the election made under Subsections (8)(a), (b), and (c).

(e) If a covered person elects to accept the amount tendered under Subsection (9)(c)(i) as partial payment of all underinsured motorist claims, the final award obtained through arbitration, litigation, or later settlement shall be reduced by any payment made by the underinsured motorist carrier under Subsection (9)(c)(i).

(f) In an arbitration proceeding on the remaining underinsured claims:

(i) the parties may not disclose to the arbitrator or arbitration panel the amount paid under Subsection (9)(c)(i) until after the arbitration award has been rendered; and

(ii) the parties may not disclose the amount of the limits of underinsured motorist benefits provided by the policy.

(g) If the final award obtained through arbitration or litigation is greater than the average of the covered person's initial written demand for payment provided for in Subsection (9)(a)(i) and the underinsured motorist carrier's initial written response provided for in Subsection (9)(c)(i), the underinsured motorist carrier shall pay:

(i) the final award obtained through arbitration or litigation, except that if the award

exceeds the policy limits of the subject underinsured motorist policy by more than $15,000, the amount shall be reduced to an amount equal to the policy limits plus $15,000; and

(ii) any of the following applicable costs:

(A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

(B) the arbitrator or arbitration panel's fee; and

(C) the reasonable costs of expert witnesses and depositions used in the presentation of evidence during arbitration or litigation.

(h) (i) The covered person shall provide an affidavit of costs within five days of an arbitration award.

(ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to which the underinsured motorist carrier objects.

(B) The objection shall be resolved by the arbitrator or arbitration panel.

(iii) The award of costs by the arbitrator or arbitration panel under Subsection (9)(g)(ii) may not exceed $5,000.

(i) (i) A covered person shall disclose all material information, other than rebuttal evidence, within 30 days after a covered person elects to submit a claim for underinsured motorist coverage benefits to binding arbitration or files litigation as specified in Subsection (9)(a).

(ii) If the information under Subsection (9)(i)(i) is not disclosed, the covered person may not recover costs or any amounts in excess of the policy under Subsection (9)(g).

(j) This Subsection (9) does not limit any other cause of action that arose or may arise against the underinsured motorist carrier from the same dispute.

(k) The provisions of this Subsection (9) only apply to motor vehicle accidents that occur on or after March 30, 2010.

(l) (i) The written demand requirement in Subsection (9)(a)(i)(A) does not affect the covered person's requirement to provide a computation of any other economic damages claimed, and the one or more respondents shall have a reasonable time after the receipt of the computation of any other economic damages claimed to conduct fact and expert discovery as to any additional damages claimed. The changes made by Laws of Utah 2014, Chapter 290, Section 11, and Chapter 300, Section 11, to this Subsection (9)(l) and Subsection (9)(a)(i)(A) apply to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

(ii) The changes made by Laws of Utah 2014, Chapter 290, Section 11, and Chapter 300, Section 11, under Subsections (9)(a)(ii)(A)(II) and (B)(II) apply to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

Section 15. Section **31A-22-602** is amended to read:

31A-22-602. Premium rates.

(1) Except as provided in Subsection 31A-22-701(4), this section does not apply to group accident and health insurance.

(2) The benefits in an accident and health insurance policy shall be reasonable in relation to the premiums charged.

(3) The commissioner shall prohibit the use of [~~a policy offering~~] an accident and health insurance form or rates if the form or rates do not satisfy Subsection (2).

Section 16. Section **31A-22-627** is amended to read:

31A-22-627. Coverage of emergency medical services.

(1) A health insurance policy or managed care organization contract:

(a) shall provide coverage of emergency services; and

(b) may not:

(i) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized;

(ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured; or

(iii) impose any cost-sharing requirement for out-of-network that exceeds the cost-sharing requirement imposed for in-network.

(2) (a) A health insurance policy or managed care organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's condition has been stabilized.

(b) If authorization described in Subsection (2)(a) is required, an insurer who does not accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected the request for authorization.

(3) For purposes of this section:

[~~(a) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention through a hospital emergency department to result in:~~]

[~~(i) placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;~~]

[~~(ii) serious impairment to bodily functions; or~~]

[~~(iii) serious dysfunction of any bodily organ or part.~~]

[~~(b)~~] (a) "Hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis.

[~~(c)~~] (b) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).

(4) Nothing in this section may be construed as:

(a) altering the level or type of benefits that are provided under the terms of a contract or policy; or

(b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract.

(5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has violated this section, the commissioner may:

(a) work with the insurer to improve the insurer's compliance with this section; or

(b) impose the following fines:

(i) not more than $5,000; or

(ii) twice the amount of any profit gained from violations of this section.

Section 17. Section **31A-22-727** is enacted to read:

31A-22-727. Renewal, cancellation, and modification.

(1) Except as provided in Section 31A-22-618.6, for a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance, an insurer may:

(a) decline to renew the policy on the date the policy term expires for a reason stated in the policy; or

(b) cancel the policy at any time for:

(i) nonpayment of a premium when due;

(ii) intentional misrepresentation of a material fact in connection with the coverage;

(iii) performance of an act or practice that constitutes fraud in connection with the coverage; or

(iv) noncompliance with an employer eligibility provision.

(2) Except for a modification required by law, an insurer may only modify a policy at renewal.

(3) Subsection (2) does not apply to an endorsement by which the insurer:

(a) effectuates a request the policyholder made in writing; or

(b) exercises a specifically reserved right under the policy.

Section 18. Section **31A-23a-111** is amended to read:

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

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

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

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

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

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

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

(d) lapsed under Section 31A-23a-113; or

(e) voluntarily surrendered.

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

(a) a lapsed license; or

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

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

(a) this title; or

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

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

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

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5);

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(iii) lapses under Section 31A-23a-113; or

(iv) is voluntarily surrendered; or

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

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

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

(5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke:

(A) a license; or

(B) a line of authority;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a line of authority;

(iii) limit in whole or in part:

(A) a license; or

(B) a line of authority;

(iv) deny a license application;

(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

(vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and

Subsection (5)(a)(v).

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee or license applicant:

(i) is unqualified for a license or line of authority under Section 31A-23a-104, 31A-23a-105, or 31A-23a-107;

(ii) violates:

(A) an insurance statute;

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

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

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person [~~in this state~~] within 60 days after the day on which the judgment became final;

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

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the insurance producer's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) violates an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;

(xi) obtains or attempts to obtain a license through misrepresentation or fraud;

(xii) improperly withholds, misappropriates, or converts money or properties received in the course of doing insurance business;

(xiii) intentionally misrepresents the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) life settlement;

(xiv) has been convicted of:

(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;

(xv) admits or is found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere:

(A) uses fraudulent, coercive, or dishonest practices; or

(B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license or other professional or occupational license, or an equivalent to an insurance license or registration, or other professional or occupational license or registration:

(A) denied;

(B) suspended;

(C) revoked; or

(D) surrendered to resolve an administrative action;

(xviii) forges another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) improperly uses notes or another reference material to complete an examination for an insurance license;

(xx) knowingly accepts insurance business from an individual who is not licensed;

(xxi) fails to comply with an administrative or court order imposing a child support obligation;

(xxii) fails to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxiii) has been convicted of violating the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;

(xxiv) engages in a method or practice in the conduct of business that endangers the legitimate interests of customers and the public; or

(xxv) has been convicted of any criminal felony involving dishonesty or breach of trust and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

(6) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(7) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in an order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval by the commissioner.

(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

(10) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 19. Section **31A-27a-104** is amended to read:

31A-27a-104. Persons covered.

(1) This chapter applies to:

(a) an insurer who:

(i) is doing, or has done, an insurance business in this state; and

(ii) against whom a claim arising from that business may exist;

(b) a person subject to examination by the commissioner;

(c) an insurer who purports to do an insurance business in this state;

(d) an insurer who has an insured who is resident in this state; and

(e) in addition to Subsections (1)(a) through (d), a person doing business as follows:

(i) under Chapter 6a, Service Contracts;

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

(iii) under Chapter 8a, Health Discount Program Consumer Protection Act;

(iv) under Chapter 9, Insurance Fraternals;

(v) under Chapter 11, Motor Clubs;

(vi) under Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups;

(vii) as a bail bond surety company under Chapter 35, Bail Bond Act;

(viii) under Chapter 37, Captive Insurance Companies Act;

(ix) a title insurance company;

(x) a prepaid health care delivery plan; and

(xi) a person not described in Subsections (1)(e)(i) through (x) that is organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state.

(2) Notwithstanding Sections 31A-1-301 and 31A-27a-102, this chapter does not apply to a person licensed by the insurance commissioner as one or more of the following in this state unless the person engages in the business of insurance as an insurer, is an affiliate as defined in Subsection 31A-1-301(5), or is a person under the control of an affiliate:

(a) an insurance agency;

(b) an insurance producer;

(c) a limited line producer;

(d) an insurance consultant;

(e) a managing general agent;

(f) reinsurance intermediary;

(g) an individual title insurance producer or agency title insurance producer;

(h) a third party administrator;

(i) an insurance adjustor;

(j) a life settlement provider; or

(k) a life settlement producer.

Section 20. Section **31A-27a-111** is amended to read:

31A-27a-111. Actions by and against the receiver.

(1) (a) An allegation by the receiver of improper or fraudulent conduct against a person may not be the basis of a defense to the enforcement of a contractual obligation owed to the insurer by a third party.

(b) Notwithstanding Subsection (1)(a), a third party described in this Subsection (1) is not barred by this section from seeking to establish independently as a defense that the conduct is materially and substantially related to the contractual obligation for which enforcement is sought.

(2) (a) Subject to Subsection (2)(b), a prior wrongful or negligent action of any present or former receiver, receiver's assistant, receiver's contractor, officer, manager, director, trustee, owner, employee, or agent of the insurer may not be asserted as a defense to a claim by the receiver:

(i) under a theory of:

(A) estoppel;

(B) comparative fault;

(C) intervening cause;

(D) proximate cause;

(E) reliance; or

(F) mitigation of damages; or

(ii) otherwise.

(b) Notwithstanding Subsection (2)(a):

(i) the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract; and

(ii) a principal under a surety bond or a surety undertaking is entitled to credit against any reimbursement obligation to the receiver for the value of any property pledged to secure the reimbursement obligation to the extent that:

(A) the receiver has possession or control of the property; or

(B) the insurer or its agents misappropriated, including commingling, the property.

(c) Evidence of fraud in the inducement is admissible only if it is contained in the

records of the insurer.

(3) Action or inaction by an insurance regulatory authority may not be asserted as a defense to a claim by the receiver.

(4) (a) Subject to Subsection (4)(b), a judgment or order entered against an insured or the insurer in contravention of a stay or injunction under this chapter, or at any time by default or collusion, may not be considered as evidence of liability or of the quantum of damages in adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.

(b) Subsection (4)(a) does not apply to an affected guaranty association's claim for amounts paid on a settlement or judgment in pursuit of the affected guaranty association's statutory obligations.

(5) (a) Subject to Subsection (5)(b), the following do not affect the amount that a receiver may recover from a third party, regardless of any provision in an agreement to the contrary:

(i) the insurer's insolvency; or

(ii) the insurer's or receiver's failure to pay all or a portion of an amount or a claim to the third party.

(b) If an agreement between the insurer and a third party requires a payment by the insurer before the insurer may recover from the third party, the amount the receiver may recover from the third party under Subsection (5)(a) is limited to an amount equal to the greater of:

(i) the amount paid by the insurer or by another person on behalf of the insurer to the third party; or

(ii) the amount allowed as a claim for payment under:

(A) an approved report described in Section 31A-27a-608;

(B) an order of the receivership court; or

(C) a plan of rehabilitation.

(6) The receiver may not be considered a governmental entity for the purposes of any state law awarding fees to a litigant who prevails against a governmental entity.

Section 21. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with this chapter, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) (a) "Bona fide employer association" means an association of employers:

(i) that meets the requirements of [~~Subsection 31A-22-701(2)(b)~~] Section 31A-22-505;

(ii) in which the employers of the association, either directly or indirectly, exercise control over the plan;

(iii) that is organized:

(A) based on a commonality of interest between the employers and their employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits; and

(B) to act in the best interests of its employers to provide benefits for the employer's employees and their spouses and dependents, and other benefits relating to employment; and

(iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

(b) The commissioner shall consider the following with regard to determining whether an association of employers is a bona fide employer association under Subsection (4)(a):

(i) how association members are solicited;

(ii) who participates in the association;

(iii) the process by which the association was formed;

(iv) the purposes for which the association was formed, and what, if any, were the pre-existing relationships of its members;

(v) the powers, rights and privileges of employer members; and

(vi) who actually controls and directs the activities and operations of the benefit programs.

(5) "Carrier" means a person that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) another person providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the commissioner in accordance with Section 31A-30-105.

(8) "Covered carrier" means an individual carrier or small employer carrier subject to this chapter.

(9) "Covered individual" means an individual who is covered under a health benefit plan subject to this chapter.

(10) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(11) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(12) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(13) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base

premium rate and the corresponding highest premium rate.

(14) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(15) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(16) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(17) "Premium" means money paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including fees or other contributions associated with the health benefit plan.

(18) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(19) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

Section 22. Section **31A-35-404** is amended to read:

31A-35-404. Minimum financial requirements for bail bond agency license.

(1) (a) A bail bond agency that pledges the assets of a letter of credit from a Utah depository institution in connection with a judicial proceeding shall maintain an irrevocable letter of credit with a minimum face value of $300,000 assigned to the state from a Utah depository institution.

(b) Notwithstanding Subsection (1)(a), a bail bond agency described in Subsection (1)(a) that is licensed under this chapter on or before December 31, 1999, shall maintain an irrevocable letter of credit with a minimum face value of $250,000 assigned to the state from a Utah depository institution.

(2) (a) A bail bond agency that pledges personal or real property, or both, as security for a bail bond in connection with a judicial proceeding shall maintain a verified financial statement for the [~~current~~] bail bond agency's immediately preceding fiscal year:

(i) reviewed by a certified public accountant; and

(ii) showing a minimum net worth of:

(A) $300,000, at least $100,000 of which is in liquid assets; or

(B) if the bail bond agency is licensed under this chapter on or before December 31, 1999, $250,000, at least $50,000 of which is in liquid assets.

(b) For purposes of this Subsection (2), only real or personal property located in Utah may be included in the net worth of the bail bond agency.

(3) A bail bond agency shall maintain a qualifying power of attorney issued by a surety insurer if:

(a) the bail bond agency is the agent of the surety insurer; and

(b) the surety insurer:

(i) sells bail bonds;

(ii) is in good standing in its state of domicile; and

(iii) is granted a certificate to write bail bonds in Utah.

(4) The commissioner may revoke the license of a bail bond agency that fails to maintain the minimum financial requirements required under this section.

(5) The commissioner may set by rule the limits on the aggregate amounts of bail bonds issued by a bail bond agency.

Section 23. Section **58-13-2.5** is amended to read:

58-13-2.5. Standard of proof for emergency care when immunity does not apply.

(1) A person who is a health care provider as defined in Section 78B-3-403 who provides emergency care in good faith, but is not immune from suit because of an expectation of payment, a legal duty to respond, or other reason under Section 58-13-2, may only be liable for civil damages if fault, as defined in Section 78B-5-817, is established by clear and convincing evidence.

(2) For purposes of Subsection (1), "emergency care" means the treatment of an emergency medical condition, as defined in Section [~~31A-22-627~~] 31A-1-301, from the time that the person presents at the emergency department of a hospital and including any subsequent transfer to another hospital, until the condition has been stabilized and the patient is either discharged from the emergency department or admitted to another department of the hospital.

(3) This section does not apply to emergency care provided by a physician if:

(a) the physician has a previously established physician/patient relationship with the patient outside of the emergency room;

(b) the patient has been seen in the last three months by the physician for the same condition for which emergency care is sought; and

(c) the physician can access and consult the patient's relevant medical care records while the physician is making decisions about and providing the emergency care.

(4) (a) Nothing in this section may be construed as:

(i) altering the applicable standard of care for determining fault; or

(ii) applying the standard of proof of clear and convincing evidence to care outside of emergency care and the mandatory legal duty to treat.

(b) This section applies to emergency care given after June 1, 2009.

(5) This section sunsets in accordance with Section 63I-1-258.

Section 24. Section **63I-1-231** is amended to read:

63I-1-231. Repeal dates, Title 31A.

(1) Section 31A-2-217, Coordination with other states, is repealed July 1, 2023.

(2) Subsections 31A-19a-209(2) and (3) are repealed July 1, 2027.

[~~(2)~~] (3) Section 31A-22-615.5 is repealed July 1, 2022.

Section 25. Section **76-6-521** is amended to read:

76-6-521. Fraudulent insurance act.

(1) A person commits a fraudulent insurance act if that person with intent to deceive or defraud:

(a) presents or causes to be presented any oral or written statement or representation knowing that the statement or representation contains false or fraudulent information concerning any fact material to an application for the issuance or renewal of an insurance policy, certificate, or contract, as part of or in support of:

(i) obtaining an insurance policy the insurer would otherwise not issue on the basis of underwriting criteria applicable to the person;

(ii) a scheme or artifice to avoid paying the premium that an insurer charges on the basis of underwriting criteria applicable to the person; or

(iii) a scheme or artifice to file an insurance claim for a loss that has already occurred;

(b) presents, or causes to be presented, any oral or written statement or representation:

(i) (A) as part of or in support of a claim for payment or other benefit pursuant to an insurance policy, certificate, or contract; or

(B) in connection with any civil claim asserted for recovery of damages for personal or bodily injuries or property damage; and

(ii) knowing that the statement or representation contains false, incomplete, or fraudulent information concerning any fact or thing material to the claim;

(c) knowingly accepts a benefit from proceeds derived from a fraudulent insurance act;

(d) intentionally, knowingly, or recklessly devises a scheme or artifice to obtain fees for professional services, or anything of value by means of false or fraudulent pretenses, representations, promises, or material omissions;

(e) knowingly employs, uses, or acts as a runner, as defined in Section 31A-31-102, for the purpose of committing a fraudulent insurance act;

(f) knowingly assists, abets, solicits, or conspires with another to commit a fraudulent insurance act;

(g) knowingly supplies false or fraudulent material information in any document or

statement required by the Department of Insurance; or

(h) knowingly fails to forward a premium to an insurer in violation of Section 31A-23a-411.1.

(2) (a) A violation of Subsection (1)(a) (i) is a class A misdemeanor.

(b) A violation of Subsections (1)(a)(ii) or (1)(b) through (1) (h) is punishable as in the manner prescribed by Section 76-10-1801 for communication fraud for property of like value.

(c) A violation of Subsection (1)(a)(iii):

(i) is a class A misdemeanor if the value of the loss is less than $1,500 or unable to be determined; or

(ii) if the value of the loss is $1,500 or more, is punishable as in the manner prescribed by Section 76-10-1801 for communication fraud for property of like value.

(3) A corporation or association is guilty of the offense of insurance fraud under the same conditions as those set forth in Section 76-2-204.

(4) The determination of the degree of any offense under Subsections (1)(a)(ii) and (1)(b) through (1)(h) shall be measured by the total value of all property, money, or other things obtained or sought to be obtained by the fraudulent insurance act or acts described in Subsections (1)(a)(ii) and (1)(b) through (1)(h).

Section 26. **Repealer.**

This bill repeals:

Section **31A-17-519, Small company exemption.**