INSURANCE RELATED AMENDMENTS

2014 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill modifies Title 31A, Insurance Code, and other related provisions, to address the regulation of insurance.

Highlighted Provisions:

This bill:

- amends definition provisions;
- provides for insurance fraud investigators being designated as law enforcement officers;
- addresses the Insurance Department Restricted Account;
- changes the date captive insurance companies are to pay a fee;
- addresses what constitutes a qualified insurer;
- modifies requirements for plan of orderly withdrawal from writing a line of insurance;
- addresses notice requirements related to a request for a hearing;
- modifies calculations related to interest payable on life insurance proceeds;
- addresses uninsured and underinsured motorist coverage;
- addresses preferred provider contract provisions;
- addresses coverage of mental health and substance use disorders;
- modifies requirements for the uniform application form and the uniform waiver of coverage form;
- amends language regarding the health benefit plan on the Health Insurance Exchange;

▸ amends language regarding open enrollment provisions;

▸ modifies language regarding dental and vision policies being offered on the Health Insurance Exchange;

▸ clarifies language related to the designated responsible licensed individual;

▸ clarifies references to the Violent Crime Control and Law Enforcement Act;

▸ modifies references to state of residence to home state;

▸ addresses requirements related to licensing when a person establishes legal residence in the state;

▸ changes requirements related to the commissioner placing a licensee on probation;

▸ repeals language related to a voluntarily surrendered license that is reinstated upon completion of continuing education requirements;

▸ modifies certain exemptions from continuing education requirements;

▸ clarifies training period requirements;

▸ changes a navigator license term to one year;

▸ provides for training periods for a navigator license;

▸ modifies continuing education requirements for a navigator;

▸ repeals the requirement that the commissioner publish a list of professional designations whose continuing education requirements could be used for certain circumstances related to navigators;

▸ modifies provisions related to inducements;

▸ addresses license compensation provisions;

▸ makes navigator licensees subject to unfair marketing practice restrictions;

▸ amends definitions specific to insurance adjusters' chapter;

▸ exempts an applicant for the crop insurance license class from certain requirements;

▸ modifies the definition of receiver;

▸ addresses the provisions related to the receivership court's seizure order;

▸ amends the purpose statement, definition, and applicability and scope provisions for the Individual, Small Employer, and Group Health Insurance Act;

▸ addresses the surcharge for groups changing carriers;

▸ addresses eligibility for the small employer and individual market;

▸ modifies the provisions related to appointment of insurance producers and the Health Insurance Exchange;

▸ modifies Health Insurance Exchange disclosure requirements;

▸ requires a captive insurance company, rather than an association captive insurance company or industrial insured group, to file a specified report;

▸ corrects a reference to a covered employee;

▸ changes reference to a multiple coordinated policy to a master policy;

▸ includes reference to the defined contribution arrangement market into the Defined Contribution Risk Adjuster Act;

▸ modifies definitions in the Small Employer Stop-Loss Insurance Act;

▸ addresses stop-loss insurance coverage standards, stop-loss restrictions, filing requirements, and stop-loss insurance disclosure;

▸ modifies commissioner's rulemaking authority under the Small Employer Stop-Loss Insurance Act; and

▸ makes technical and conforming amendments.

Money Appropriated in this Bill:

This bill reduces appropriations beginning in fiscal year 2015 from the Insurance Department Restricted Account by $403,500.

Other Special Clauses:

This bill provides an effective date.

This bill provides revisor instructions.

Utah Code Sections Affected:

AMENDS:

31A-1-301, as last amended by Laws of Utah 2013, Chapter 319

31A-2-104, as last amended by Laws of Utah 1999, Chapter 21

31A-3-103, as last amended by Laws of Utah 2011, Chapter 284

31A-3-304 **(Superseded 07/01/15)**, as last amended by Laws of Utah 2011, Chapter 284

31A-3-304 **(Effective 07/01/15)**, as last amended by Laws of Utah 2013, Chapter 319

31A-4-102, as last amended by Laws of Utah 2008, Chapter 345

31A-4-115, as last amended by Laws of Utah 2002, Chapter 308

31A-8-402.3, as last amended by Laws of Utah 2004, Chapter 329

31A-16-103, as last amended by Laws of Utah 2004, Chapter 2

31A-17-607, as last amended by Laws of Utah 2001, Chapter 116

31A-22-305, as last amended by Laws of Utah 2013, Chapter 460

31A-22-305.3, as last amended by Laws of Utah 2013, Chapter 460

31A-22-428, as enacted by Laws of Utah 2008, Chapter 345

31A-22-617, as last amended by Laws of Utah 2013, Chapters 104 and 319

31A-22-618.5, as last amended by Laws of Utah 2013, Chapter 319

31A-22-625, as last amended by Laws of Utah 2012, Chapter 253

31A-22-635, as last amended by Laws of Utah 2012, Chapters 253 and 279

31A-22-721, as last amended by Laws of Utah 2011, Chapter 284

31A-23a-102, as last amended by Laws of Utah 2013, Chapter 319

31A-23a-104, as last amended by Laws of Utah 2012, Chapter 253

31A-23a-105, as last amended by Laws of Utah 2013, Chapter 319

31A-23a-108, as last amended by Laws of Utah 2012, Chapter 253

31A-23a-112, as last amended by Laws of Utah 2008, Chapter 382

31A-23a-113, as last amended by Laws of Utah 2012, Chapter 253

31A-23a-202, as last amended by Laws of Utah 2013, Chapter 319

31A-23a-203, as last amended by Laws of Utah 2012, Chapter 253

31A-23a-402.5, as last amended by Laws of Utah 2013, Chapter 319

31A-23a-501, as last amended by Laws of Utah 2013, Chapter 341

31A-23b-102, as enacted by Laws of Utah 2013, Chapter 341

31A-23b-202, as enacted by Laws of Utah 2013, Chapter 341

31A-23b-205, as enacted by Laws of Utah 2013, Chapter 341
31A-23b-206, as enacted by Laws of Utah 2013, Chapter 341
31A-23b-301, as enacted by Laws of Utah 2013, Chapter 341
31A-23b-402, as enacted by Laws of Utah 2013, Chapter 341
31A-25-208, as last amended by Laws of Utah 2011, Chapter 284
31A-25-209, as last amended by Laws of Utah 2008, Chapter 382
31A-26-102, as last amended by Laws of Utah 2012, Chapter 151
31A-26-206, as last amended by Laws of Utah 2011, Chapter 284
31A-26-207, as last amended by Laws of Utah 2001, Chapter 116
31A-26-213, as last amended by Laws of Utah 2011, Chapter 284
31A-26-214, as last amended by Laws of Utah 2008, Chapter 382
31A-26-214.5, as last amended by Laws of Utah 2009, Chapter 349
31A-27a-102, as last amended by Laws of Utah 2008, Chapter 382
31A-27a-107, as enacted by Laws of Utah 2007, Chapter 309
31A-27a-201, as enacted by Laws of Utah 2007, Chapter 309
31A-27a-701, as last amended by Laws of Utah 2011, Chapter 297
31A-29-106, as last amended by Laws of Utah 2013, Chapter 319
31A-29-111, as last amended by Laws of Utah 2012, Chapters 158 and 347
31A-29-115, as last amended by Laws of Utah 2004, Chapter 2
31A-30-102, as last amended by Laws of Utah 2009, Chapter 12
31A-30-103, as last amended by Laws of Utah 2013, Chapter 168
31A-30-104, as last amended by Laws of Utah 2013, Chapters 168 and 341
31A-30-106, as last amended by Laws of Utah 2011, Chapter 284
31A-30-106.7, as last amended by Laws of Utah 2008, Chapter 382
31A-30-107, as last amended by Laws of Utah 2009, Chapter 12
31A-30-108, as last amended by Laws of Utah 2011, Chapter 284
31A-30-207, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5
31A-30-209, as last amended by Laws of Utah 2011, Chapter 400

31A-30-211, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5
31A-37-501, as last amended by Laws of Utah 2008, Chapter 302
31A-40-203, as enacted by Laws of Utah 2008, Chapter 318
31A-40-209, as enacted by Laws of Utah 2008, Chapter 318
31A-42-202, as last amended by Laws of Utah 2011, Chapter 400
31A-43-102, as enacted by Laws of Utah 2013, Chapter 341
31A-43-301, as enacted by Laws of Utah 2013, Chapter 341
31A-43-302, as enacted by Laws of Utah 2013, Chapter 341
31A-43-303, as enacted by Laws of Utah 2013, Chapter 341
31A-43-304, as enacted by Laws of Utah 2013, Chapter 341
53-13-103, as last amended by Laws of Utah 2011, Chapter 58
63J-1-602.2, as last amended by Laws of Utah 2013, Chapter 338

REPEALS:

31A-30-110, as last amended by Laws of Utah 2011, Chapters 284 and 297
31A-30-111, as last amended by Laws of Utah 2002, Chapter 308

Utah Code Sections Affected by Revisor Instructions:

31A-22-305, as last amended by Laws of Utah 2013, Chapter 460
31A-22-305.3, as last amended by Laws of Utah 2013, Chapter 460

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

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

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

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

(3) "Administrator" is defined in Subsection [~~(163)~~] (164).

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

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

(6) "Agency" means:

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

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

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

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

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

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

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

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

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

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

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

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

(13) "Binder" is defined in Section 31A-21-102.

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

(a) without individual underwriting or application; and

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

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

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

(a) that is open to the public;

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

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

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(18) "Business of insurance" is defined in Subsection (88).

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

(a) Section 31A-7-201;

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

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

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

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

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by another organization; and

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

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

(i) owned by the insureds; and

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

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

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

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

(b) a third party.

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

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

(26) "Claims-made coverage" means an insurance contract or provision limiting

coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force.

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

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

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

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

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

(A) for the life of the insured; or

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

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

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

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

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

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

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

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

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

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

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

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

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

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

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

(iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. 109-415.

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

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

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

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

(38) "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.

(39) "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.

(40) "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.

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

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

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

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

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

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

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

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

(46) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(49) "Disability income insurance" is defined in Subsection (79).

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

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

(b) "Eligible employee" includes, if the individual is included under a health benefit plan of a small employer:

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

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

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

(ii) an employer's spouse; or

(iii) a dependent of an employer.

(53) "Employee" means an individual employed by an employer.

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

(a) an employee; or

(b) a dependent of an employee.

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

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

(A) one or more employers;

(B) one or more labor organizations; or

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

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

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

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

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

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

(57) "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.

(58) (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.

(59) "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.

(60) (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.

(61) "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.

(62) "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.

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

(64) (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 (64)(a).

(65) "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; or

(o) an outline of coverage.

(66) "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.

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

(68) (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.

(69) "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.

(70) "General lines of authority" include:

(a) the general lines of insurance in Subsection (71);

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

(i) search, 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) [~~any other~~] another line of insurance that the commissioner considers necessary to recognize in the public interest.

(71) "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.

(72) "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.

(73) (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.

(74) "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.

(75) (a) Except as provided in Subsection (75)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

(iii) is offered as a substitute for hospital or medical expense insurance, such as:

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

(b) "Health benefit plan" does not include a policy or certificate that:

(i) provides benefits solely for:

(A) accident;

(B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

(G) vision; or

(H) a short-term limited duration; or

(ii) is offered and marketed as supplemental health insurance.

(76) "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.

(77) (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.

(78) "Health Insurance Portability and Accountability Act" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended.

(79) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

(80) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

(81) "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.

(82) "Independently procured insurance" means insurance procured under Section 31A-15-104.

(83) "Individual" means a natural person.

(84) "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.

(85) "Insolvency" means that:

(a) an insurer is unable to pay its debts or meet its obligations as the debts and obligations mature;

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

(c) an insurer is determined to be hazardous under this title.

(86) (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.

(87) "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.

(88) "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 (116);

(e) providing another person with insurance;

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections (88)(a) through (h) in a manner designed to evade this title.

(89) "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.

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

(91) (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."

(92) (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 (92)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in an insurance policy or certificate.

(93) (a) "Insurer" means a person doing an insurance business as a principal including:

(i) a fraternal benefit society;

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

(iii) a motor club;

(iv) an employee welfare plan; and

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

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

(94) "Interinsurance exchange" is defined in Subsection [~~(146)~~] (147).

(95) "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.

(96) "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 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

(97) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

(98) "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.

(99) (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.

(100) (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) Subsection (110) for medical malpractice insurance;

(B) Subsection (138) for professional liability insurance; and

(C) Subsection [~~(172)~~] (173) for 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) Subsection (110) for medical malpractice insurance;

(B) Subsection (138) for professional liability insurance; and

(C) Subsection [~~(172)~~] (173) for 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.

(101) (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.

(102) (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.

(103) "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.

(104) "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.

(105) "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.

(106) "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.

(107) "Limited lines authority" includes[~~: (a)~~] the lines of insurance listed in Subsection (106)[~~; and~~].

[~~(b) a customer service representative.~~]

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

(109) (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 (109)(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.

(110) "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.

(111) "Member" means a person having membership rights in an insurance corporation.

(112) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

(113) "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.

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

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

(116) "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 (116)(b)(iii)(A) through (D); or

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

(117) "Mutual" means a mutual insurance corporation.

(118) "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.

(119) "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.

(120) "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.

(121) "Order" means an order of the commissioner.

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

(123) "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.

(124) "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.

(125) "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.

(126) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

(127) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

(128) "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 (128)(a) or (b), the calendar year.

(129) (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.

(130) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

(131) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

(132) "Policy summary" means a synopsis describing the elements of a life insurance policy.

(133) "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.

(134) "Preexisting condition," with respect to a health benefit plan:

(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.

(135) (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.

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

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

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

(139) (a) Except as provided in Subsection (139)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

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

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

(140) "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.

(141) "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.

(142) (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.

(143) (a) Except as provided in Subsection (143)(b), "rate service organization" means a person who assists an insurer in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

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

(144) "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.

(145) (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.

[~~(145)~~] (146) "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.

[~~(146)~~] (147) "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.

[~~(147)~~] (148) "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."

[~~(148)~~] (149) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(149)~~] (150) "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.

[~~(150)~~] (151) (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.

[~~(151)~~] (152) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(152)~~] (153) (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 [~~(152)~~] (153)(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.

[~~(153)~~] (154) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

[~~(154)~~] (155) (a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

(b) Except as provided in this Subsection [~~(154)~~] (155), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(c) "Self-insurance" includes:

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

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

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

[~~(155)~~] (156) "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.

[~~(156)~~] (157) "Short-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.

[~~(157)~~] (158) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.

[~~(158)~~] (159) "Small employer[;]" means, in connection with a health benefit plan[~~, means an employer who,~~] and with respect to a calendar year and to a plan year, an employer who:

(a) employed [~~an average of~~] at least [~~two employees~~] one employee but not more than an average of 50 eligible employees on [~~each~~] business [~~day~~] days during the preceding calendar year; and

(b) employs at least [~~two employees~~] one employee on the first day of the plan year.

[~~(159)~~] (160) "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.

[~~(160)~~] (161) (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.

[~~(161)~~] (162) Subject to Subsection (86)(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.

[~~(162)~~] (163) (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).

[~~(163)~~] (164) "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.

[~~(164)~~] (165) "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.

[~~(165)~~] (166) "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.

[~~(166)~~] (167) (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.

[~~(167)~~] (168) (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) transcribing business as authorized by a valid certificate.

[~~(168)~~] (169) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(169)~~] (170) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage under Subsection (139).

[~~(170)~~] (171) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

[~~(171)~~] (172) "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.

[~~(172)~~] (173) "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 2. Section **31A-2-104** is amended to read:

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

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

(2) An insurance fraud investigator employed pursuant to Subsection (1) may as approved by the commissioner:

(a) be designated a [~~special function~~] law enforcement officer, as defined in Section [~~53-13-105, by the commissioner, but is not~~] 53-13-103; and

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

Section 3. Section **31A-3-103** is amended to read:

31A-3-103. Fees.

(1) For purposes of this section, "services" means functions that are reasonable and necessary to enable the commissioner to perform the duties imposed by this title including:

(a) issuing or renewing a license or certificate of authority;

(b) filing a policy form;

(c) reporting a producer appointment or termination; and

(d) filing an annual statement.

(2) Except as otherwise provided by this title:

(a) the commissioner may set and collect a fee for services provided by the commissioner;

(b) a fee related to the renewal of a license may be imposed no more frequently than once each year; and

(c) a fee charged by the commissioner shall be set in accordance with Section 63J-1-504.

(3) (a) The commissioner shall publish a schedule of fees established pursuant to this section.

(b) The commissioner shall, by rule, establish the deadlines for payment of a fee established pursuant to this section.

(4) (a) [~~Beginning July 1, 2011, there~~] There is created in the General Fund a restricted account known as the "Insurance Department Restricted Account."

(b) Except as provided in Subsection (4)(c), the Insurance Department Restricted Account shall consist of:

(i) fees authorized by this section; and

(ii) other money received by the department, including:

(A) reimbursements for examination costs incurred by the department; and

(B) forfeitures collected under this title.

(c) The department shall deposit money it receives that is subject to a restricted account or enterprise fund created by this title into the restricted account or enterprise fund in accordance with the statute creating the restricted account or enterprise fund, and the department may not deposit the money into the Insurance Department Restricted Account.

(d) Subject to appropriation by the Legislature, the department may expend money in the Insurance Department Restricted Account to fund the operations of the department.

(e) (i) At the end of each fiscal year until June 30, 2015, the director of the Division of Finance shall transfer into the General Fund any money deposited into the Insurance Department Restricted Account under Subsection (4)(b) that exceeds the legislative appropriations from the Insurance Department Restricted Account for that year.

(ii) Beginning with fiscal year 2015-2016, an appropriation of the Insurance Department Restricted Account is nonlapsing, except that at the end of each fiscal year, money received by the commissioner in excess of $8,146,500 shall be treated as free revenue in the General Fund.

Section 4. Section **31A-3-304 (Superseded 07/01/15)** is amended to read:

31A-3-304 (Superseded 07/01/15). Annual fees -- Other taxes or fees prohibited -- Captive Insurance Restricted Account.

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

(b) The commissioner shall:

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

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

(2) A captive insurance company that fails to pay the fee required by this section is subject to the relevant sanctions of this title.

(3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under

the laws of this state that may be levied or assessed on a captive insurance company:

(i) a fee under this section;

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

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

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

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

(d) A captive insurance company is subject to real and personal property taxes.

(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June [~~20~~] 1 of each year.

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

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

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

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

(i) administer and enforce:

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

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

(ii) promote the captive insurance industry in Utah.

(e) An appropriation from the Captive Insurance Restricted Account is nonlapsing, except that at the end of each fiscal year, money received by the commissioner in excess of

$950,000 shall be treated as free revenue in the General Fund.

Section 5. Section **31A-3-304 (Effective 07/01/15)** is amended to read:

31A-3-304 (Effective 07/01/15). Annual fees -- Other taxes or fees prohibited -- Captive Insurance Restricted Account.

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

(b) The commissioner shall:

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

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

(2) A captive insurance company that fails to pay the fee required by this section is subject to the relevant sanctions of this title.

(3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under the laws of this state that may be levied or assessed on a captive insurance company:

(i) a fee under this section;

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

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

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

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

(d) A captive insurance company is subject to real and personal property taxes.

(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June [~~20~~] 1 of each year.

(5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be

deposited into the Captive Insurance Restricted Account.

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

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

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

(i) administer and enforce:

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

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

(ii) promote the captive insurance industry in Utah.

(e) An appropriation from the Captive Insurance Restricted Account is nonlapsing, except that at the end of each fiscal year, money received by the commissioner in excess of $1,250,000 shall be treated as free revenue in the General Fund.

Section 6. Section **31A-4-102** is amended to read:

31A-4-102. Qualified insurers.

(1) A person may not conduct an insurance business in Utah in person, through an agent, through a broker, through the mail, or through another method of communication, except:

(a) an insurer:

(i) authorized to do business in Utah under [~~Chapter 5, 7, 8, 9, 10, 11, 13, or 14; and~~]:

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

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

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

(D) Chapter 9, Insurance Fraternals;

(E) Chapter 10, Annuities;

(F) Chapter 11, Motor Clubs;

(G) Chapter 13, Employee Welfare Funds and Plans;

(H) Chapter 14, Foreign Insurers;

(I) Chapter 37, Captive Insurance Companies Act; or

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

(ii) within the limits of its certificate of authority;

(b) a joint underwriting group under Section 31A-2-214 or 31A-20-102;

(c) an insurer doing business under Section 31A-15-103;

(d) a person who submits to the commissioner a certificate from the United States Department of Labor, or such other evidence as satisfies the commissioner, that the laws of Utah are preempted with respect to specified activities of that person by Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law; or

(e) a person exempt from this title under Section 31A-1-103 or another applicable statute.

(2) As used in this section, "insurer" includes a bail bond surety company, as defined in Section 31A-35-102.

Section 7. Section **31A-4-115** is amended to read:

31A-4-115. Plan of orderly withdrawal.

(1) (a) When an insurer intends to withdraw from writing a line of insurance in this state or to reduce its total annual premium volume by 75% or more, the insurer shall file with the commissioner a plan of orderly withdrawal.

(b) For purposes of this section, a discontinuance of a health benefit plan pursuant to one of the following provisions is a withdrawal from a line of insurance:

(i) Subsection 31A-30-107(3)(e); or

(ii) Subsection 31A-30-107.1(3)(e).

(2) An insurer's plan of orderly withdrawal shall:

(a) indicate the date the insurer intends to begin and complete its withdrawal plan; and

(b) include provisions for:

(i) meeting the insurer's contractual obligations;

(ii) providing services to its Utah policyholders and claimants;

(iii) meeting [~~any~~] applicable statutory obligations; and

(iv) [~~(A)~~] the payment of a withdrawal fee of $50,000 to the [~~Utah Comprehensive Health Insurance Pool if: (I) the insurer is an accident and health insurer; and (II) the insurer's line of business is not assumed or placed with another insurer approved by the commissioner; or (B) the payment of a withdrawal fee of $50,000 to the department if: (I) the insurer is not an accident and health insurer; and (II)~~] department if the insurer's line of business is not assumed or placed with another insurer approved by the commissioner.

(3) The commissioner shall approve a plan of orderly withdrawal if the plan of orderly withdrawal adequately demonstrates that the insurer will:

(a) protect the interests of the people of the state;

(b) meet the insurer's contractual obligations;

(c) provide service to the insurer's Utah policyholders and claimants; and

(d) meet [~~any~~] applicable statutory obligations.

(4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for orderly withdrawal.

(5) The commissioner may require an insurer to increase the deposit maintained in accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in the name of the commissioner upon finding, after an adjudicative proceeding that:

(a) there is reasonable cause to conclude that the interests of the people of the state are best served by such action; and

(b) the insurer:

(i) has filed a plan of orderly withdrawal; or

(ii) intends to:

(A) withdraw from writing a line of insurance in this state; or

(B) reduce the insurer's total annual premium volume by 75% or more.

(6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:

(a) withdraws from writing insurance in this state without receiving the commissioner's approval of a plan of orderly withdrawal; or

(b) reduces its total annual premium volume by 75% or more in any year without [~~having submitted a plan or receiving the commissioner's approval~~] receiving the commissioner's approval of a plan of orderly withdrawal.

(7) An insurer that withdraws from writing all lines of insurance in this state may not resume writing insurance in this state for five years unless[~~: (a)~~] the commissioner finds that the prohibition should be waived because the waiver is:

[~~(i)~~] (a) in the public interest to promote competition; or

[~~(ii)~~] (b) to resolve inequity in the marketplace[~~; and~~].

[~~(b) the insurer complies with Subsection 31A-30-108(5), if applicable.~~]

(8) The commissioner shall adopt rules necessary to implement this section.

Section 8. Section **31A-8-402.3** is amended to read:

31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit plans.

(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

(a) for a network plan, if[~~: (i)~~] there is no longer any enrollee under the group health plan who lives, resides, or works in:

[~~(A)~~] (i) the service area of the insurer; or

[~~(B)~~] (ii) the area for which the insurer is authorized to do business; [~~and~~] or

[~~(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or~~]

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A health benefit plan for a plan sponsor may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:

(I) all other health benefit products currently being offered by the insurer in the market; or

(II) in the case of a large employer, any other health benefit product currently being offered in that market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A large employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's employer contribution requirements.

(6) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's minimum participation requirements.

(7) (a) Except as provided in Subsection (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (7) because of a fraud or misrepresentation that relates to health status.

(8) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the health benefit plan is made available by an insurer in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(9) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 9. Section **31A-16-103** is amended to read:

31A-16-103. Acquisition of control of or merger with domestic insurer.

(1) (a) A person may not take the actions described in Subsections (1)(b) or (c) unless, at the time any offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of securities if no offer or agreement is involved:

(i) the person files with the commissioner a statement containing the information required by this section;

(ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the insurer; and

(iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.

(b) Unless the person complies with Subsection (1)(a), a person other than the issuer may not make a tender offer for, a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise, any voting security of a domestic insurer if after the acquisition, the person would directly, indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.

(c) Unless the person complies with Subsection (1)(a), a person may not enter into an agreement to merge with or otherwise to acquire control of:

(i) a domestic insurer; or

(ii) any person controlling a domestic insurer.

(d) (i) For purposes of this section, a domestic insurer includes any person controlling a domestic insurer unless the person as determined by the commissioner is either directly or through its affiliates primarily engaged in business other than the business of insurance.

(ii) The controlling person described in Subsection (1)(d)(i) shall file with the commissioner a preacquisition notification containing the information required in Subsection (2) 30 calendar days before the proposed effective date of the acquisition.

(iii) For the purposes of this section, "person" does not include any securities broker that in the usual and customary brokers function holds less than 20% of:

(A) the voting securities of an insurance company; or

(B) any person that controls an insurance company.

(iv) This section applies to all domestic insurers and other entities licensed under Chapters 5, 7, 8, 9, and 11.

(e) (i) An agreement for acquisition of control or merger as contemplated by this Subsection (1) is not valid or enforceable unless the agreement:

(A) is in writing; and

(B) includes a provision that the agreement is subject to the approval of the commissioner upon the filing of any applicable statement required under this chapter.

(ii) A written agreement for acquisition or control that includes the provision described in Subsection (1)(e)(i) satisfies the requirements of this Subsection (1).

(2) The statement to be filed with the commissioner under Subsection (1) shall be made under oath or affirmation and shall contain the following information:

(a) the name and address of the "acquiring party," which means each person by whom or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to be effected; and

(i) if the person is an individual:

(A) the person's principal occupation;

(B) a listing of all offices and positions held by the person during the past five years; and

(C) any conviction of crimes other than minor traffic violations during the past 10 years; and

(ii) if the person is not an individual:

(A) a report of the nature of its business operations during:

(I) the past five years; or

(II) for any lesser period as the person and any of its predecessors has been in existence;

(B) an informative description of the business intended to be done by the person and the person's subsidiaries;

(C) a list of all individuals who are or who have been selected to become directors or executive officers of the person, or individuals who perform, or who will perform functions appropriate to such positions; and

(D) for each individual described in Subsection (2)(a)(ii)(C), the information required by Subsection (2)(a)(i) for each individual;

(b) (i) the source, nature, and amount of the consideration used or to be used in effecting the merger or acquisition of control;

(ii) a description of any transaction in which funds were or are to be obtained for the purpose of effecting the merger or acquisition of control, including any pledge of:

(A) the insurer's stock; or

(B) the stock of any of the insurer's subsidiaries or controlling affiliates; and

(iii) the identity of persons furnishing the consideration;

(c) (i) fully audited financial information, or other financial information considered acceptable by the commissioner, of the earnings and financial condition of each acquiring party for:

(A) the preceding five fiscal years of each acquiring party; or

(B) any lesser period the acquiring party and any of its predecessors shall have been in existence; and

(ii) unaudited information:

(A) similar to the information described in Subsection (2)(c)(i); and

(B) prepared within the 90 days prior to the filing of the statement;

(d) any plans or proposals which each acquiring party may have to:

(i) liquidate the insurer;

(ii) sell its assets;

(iii) merge or consolidate the insurer with any person; or

(iv) make any other material change in the insurer's:

(A) business;

(B) corporate structure; or

(C) management;

(e) (i) the number of shares of any security referred to in Subsection (1) that each acquiring party proposes to acquire;

(ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in Subsection (1); and

(iii) a statement as to the method by which the fairness of the proposal was arrived at;

(f) the amount of each class of any security referred to in Subsection (1) that:

(i) is beneficially owned; or

(ii) concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) a full description of any contract, arrangement, or understanding with respect to any security referred to in Subsection (1) in which any acquiring party is involved, including:

(i) the transfer of any of the securities;

(ii) joint ventures;

(iii) loan or option arrangements;

(iv) puts or calls;

(v) guarantees of loans;

(vi) guarantees against loss or guarantees of profits;

(vii) division of losses or profits; or

(viii) the giving or withholding of proxies;

(h) a description of the purchase by any acquiring party of any security referred to in Subsection (1) during the 12 calendar months preceding the filing of the statement including:

(i) the dates of purchase;

(ii) the names of the purchasers; and

(iii) the consideration paid or agreed to be paid for the purchase;

(i) a description of:

(i) any recommendations to purchase by any acquiring party any security referred to in Subsection (1) made during the 12 calendar months preceding the filing of the statement; or

(ii) any recommendations made by anyone based upon interviews or at the suggestion of the acquiring party;

(j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in Subsection (1); and

(ii) if distributed, copies of additional soliciting material relating to the transactions described in Subsection (2)(j)(i);

(k) (i) the term of any agreement, contract, or understanding made with, or proposed to be made with, any broker-dealer as to solicitation of securities referred to in Subsection (1) for tender; and

(ii) the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard to any agreement, contract, or understanding described in Subsection (2)(k)(i); and

(l) any additional information the commissioner requires by rule, which the commissioner determines to be:

(i) necessary or appropriate for the protection of policyholders of the insurer; or

(ii) in the public interest.

(3) The department may request:

(a) (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(b) Information obtained by the department from the review of criminal history records received under Subsection (3)(a) shall be used by the department for the purpose of:

(i) verifying the information in Subsection (2)(a)(i);

(ii) determining the integrity of persons who would control the operation of an insurer; and

(iii) preventing persons who violate 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~] from engaging in the business of insurance in the state.

(c) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(a)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(a)(ii); and

(iii) charge the person required to file the statement referred to in Subsection (1) a fee equal to the aggregate of Subsections (3)(c)(i) and (ii).

(4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing the statement so requests.

(b) (i) Under Subsection (2)(e), the commissioner may require a statement of the adjusted book value assigned by the acquiring party to each security in arriving at the terms of the offer.

(ii) For purposes of this Subsection (4)(b), "adjusted book value" means each security's proportional interest in the capital and surplus of the insurer with adjustments that reflect:

(A) market conditions;

(B) business in force; and

(C) other intangible assets or liabilities of the insurer.

(c) The description required by Subsection (2)(g) shall identify the persons with whom the contracts, arrangements, or understandings have been entered into.

(5) (a) If the person required to file the statement referred to in Subsection (1) is a partnership, limited partnership, syndicate, or other group, the commissioner may require that all the information called for by Subsections (2), (3), or (4) shall be given with respect to each:

(i) partner of the partnership or limited partnership;

(ii) member of the syndicate or group; and

(iii) person who controls the partner or member.

(b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation, or if the person required to file the statement referred to in Subsection (1) is a corporation, the commissioner may require that the information called for by Subsection (2) shall be given with respect to:

(i) the corporation;

(ii) each officer and director of the corporation; and

(iii) each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of the corporation.

(6) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to Subsection (2), an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two business days after the filing person learns of such change.

(7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection (1) is proposed to be made by means of a registration statement under the Securities Act of 1933, or under circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, a person required to file the statement referred to in Subsection (1) may use copies of any registration or disclosure documents in furnishing the information called for by the statement.

(8) (a) The commissioner shall approve any merger or other acquisition of control referred to in Subsection (1) unless, after a public hearing on the merger or acquisition, the commissioner finds that:

(i) after the change of control, the domestic insurer referred to in Subsection (1) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(ii) the effect of the merger or other acquisition of control would:

(A) substantially lessen competition in insurance in this state; or

(B) tend to create a monopoly in insurance;

(iii) the financial condition of any acquiring party might:

(A) jeopardize the financial stability of the insurer; or

(B) prejudice the interest of:

(I) its policyholders; or

(II) any remaining securityholders who are unaffiliated with the acquiring party;

(iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in Subsection (1) are unfair and unreasonable to the securityholders of the insurer;

(v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its assets, or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are:

(A) unfair and unreasonable to policyholders of the insurer; and

(B) not in the public interest; or

(vi) the competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of the policyholders of the insurer and the public to permit the merger or other acquisition of control.

(b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not be considered unfair if the adjusted book values under Subsection (2)(e):

(i) are disclosed to the securityholders; and

(ii) determined by the commissioner to be reasonable.

(9) (a) The public hearing referred to in Subsection (8) shall be held within 30 days after the statement required by Subsection (1) is filed.

(b) (i) At least 20 days notice of the hearing shall be given by the commissioner to the person filing the statement.

(ii) Affected parties may waive the notice required by this Subsection (9)(b).

(iii) Not less than seven days notice of the public hearing shall be given by the person filing the statement to:

(A) the insurer; and

(B) any person designated by the commissioner.

(c) The commissioner shall make a determination within 30 days after the conclusion of the hearing.

(d) At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected by the hearing may:

(i) present evidence;

(ii) examine and cross-examine witnesses; and

(iii) offer oral and written arguments.

(e) (i) A person or insurer described in Subsection (9)(d) may conduct discovery proceedings in the same manner as is presently allowed in the district courts of this state.

(ii) All discovery proceedings shall be concluded not later than three days before the commencement of the public hearing.

(10) (a) The commissioner may retain technical experts to assist in reviewing all, or a portion of, information filed in connection with a proposed merger or other acquisition of control referred to in Subsection (1).

(b) In determining whether any of the conditions in Subsection (8) exist, the commissioner may consider the findings of technical experts employed to review applicable filings.

(c) (i) A technical expert employed under Subsection (10)(a) shall present to the commissioner a statement of all expenses incurred by the technical expert in conjunction with the technical expert's review of a proposed merger or other acquisition of control.

(ii) At the commissioner's direction the acquiring person shall compensate the technical expert at customary rates for time and expenses:

(A) necessarily incurred; and

(B) approved by the commissioner.

(iii) The acquiring person shall:

(A) certify the consolidated account of all charges and expenses incurred for the review by technical experts;

(B) retain a copy of the consolidated account described in Subsection (10)(c)(iii)(A); and

(C) file with the department as a public record a copy of the consolidated account described in Subsection (10)(c)(iii)(A).

(11) (a) (i) If a domestic insurer proposes to merge into another insurer, any securityholder electing to exercise a right of dissent may file with the insurer a written request for payment of the adjusted book value given in the statement required by Subsection (1) and approved under Subsection (8), in return for the surrender of the security holder's securities.

(ii) The request described in Subsection (11)(a)(i) shall be filed not later than 10 days after the day of the securityholders' meeting where the corporate action is approved.

(b) The dissenting securityholder is entitled to and the insurer is required to pay to the dissenting securityholder the specified value within 60 days of receipt of the dissenting security holder's security.

(c) Persons electing under this Subsection (11) to receive cash for their securities waive the dissenting shareholder and appraisal rights otherwise applicable under Title 16, Chapter 10a, Part 13, Dissenters' Rights.

(d) (i) This Subsection (11) provides an elective procedure for dissenting securityholders to resolve their objections to the plan of merger.

(ii) This section does not restrict the rights of dissenting securityholders under Title 16, Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this Subsection (11).

(12) (a) All statements, amendments, or other material filed under Subsection (1), and all notices of public hearings held under Subsection (8), shall be mailed by the insurer to its securityholders within five business days after the insurer has received the statements, amendments, other material, or notices.

(b) (i) Mailing expenses shall be paid by the person making the filing.

(ii) As security for the payment of mailing expenses, that person shall file with the commissioner an acceptable bond or other deposit in an amount determined by the commissioner.

(13) This section does not apply to any offer, request, invitation, agreement, or acquisition that the commissioner by order exempts from the requirements of this section as:

(a) not having been made or entered into for the purpose of, and not having the effect of, changing or influencing the control of a domestic insurer; or

(b) [~~as~~] otherwise not comprehended within the purposes of this section.

(14) The following are violations of this section:

(a) the failure to file any statement, amendment, or other material required to be filed pursuant to Subsections (1), (2), and (5); or

(b) the effectuation, or any attempt to effectuate, an acquisition of control of or merger with a domestic insurer unless the commissioner has given the commissioner's approval to the acquisition or merger.

(15) (a) The courts of this state are vested with jurisdiction over:

(i) a person who:

(A) files a statement with the commissioner under this section; and

(B) is not resident, domiciled, or authorized to do business in this state; and

(ii) overall actions involving persons described in Subsection (15)(a)(i) arising out of a violation of this section.

(b) A person described in Subsection (15)(a) is considered to have performed acts equivalent to and constituting an appointment of the commissioner by that person, to be that person's lawful agent upon whom may be served all lawful process in any action, suit, or proceeding arising out of a violation of this section.

(c) A copy of a lawful process described in Subsection (15)(b) shall be:

(i) served on the commissioner; and

(ii) transmitted by registered or certified mail by the commissioner to the person at that person's last-known address.

Section 10. Section **31A-17-607** is amended to read:

31A-17-607. Hearings.

(1) (a) Following receipt of a notice described in Subsection (2), the insurer or health organization shall have the right to a confidential departmental hearing at which the insurer or health organization may challenge [~~any~~] a determination or action by the commissioner.

(b) The insurer or health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under [~~Subsections 31A-17-604(1), (2), and (3)~~] Subsection (2).

(c) Upon receipt of the insurer's or health organization's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 30 days after the date of the insurer's or health organization's request.

(2) An insurer or health organization has the right to a hearing under Subsection (1) after:

(a) notification to an insurer or health organization by the commissioner of an adjusted RBC report;

(b) notification to an insurer or health organization by the commissioner that:

(i) the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer or health organization;

(c) notification to any insurer or health organization by the commissioner that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event with respect to the insurer or health organization in accordance with its RBC plan or revised RBC plan; or

(d) notification to an insurer or health organization by the commissioner of a corrective order with respect to the insurer or health organization.

Section 11. Section **31A-22-305** is amended to read:

31A-22-305. Uninsured motorist coverage.

(1) As used in this section, "covered persons" includes:

(a) the named insured;

(b) for a claim arising on or after May 13, 2014, the named insured's dependent minor children;

[~~(b)~~] (c) persons related to the named insured by blood, marriage, adoption, or guardianship, who are residents of the named insured's household, including those who usually make their home in the same household but temporarily live elsewhere;

[~~(c)~~] (d) any person occupying or using a motor vehicle:

(i) referred to in the policy; or

(ii) owned by a self-insured; and

[~~(d)~~] (e) any person who is entitled to recover damages against the owner or operator of the uninsured or underinsured motor vehicle because of bodily injury to or death of persons under Subsection (1)(a), (b), [~~or~~] (c), or (d).

(2) As used in this section, "uninsured motor vehicle" includes:

(a) (i) a motor vehicle, the operation, maintenance, or use of which is not covered under a liability policy at the time of an injury-causing occurrence; or

(ii) (A) a motor vehicle covered with lower liability limits than required by Section 31A-22-304; and

(B) the motor vehicle described in Subsection (2)(a)(ii)(A) is uninsured to the extent of the deficiency;

(b) an unidentified motor vehicle that left the scene of an accident proximately caused by the motor vehicle operator;

(c) a motor vehicle covered by a liability policy, but coverage for an accident is disputed by the liability insurer for more than 60 days or continues to be disputed for more than 60 days; or

(d) (i) an insured motor vehicle if, before or after the accident, the liability insurer of the motor vehicle is declared insolvent by a court of competent jurisdiction; and

(ii) the motor vehicle described in Subsection (2)(d)(i) is uninsured only to the extent that the claim against the insolvent insurer is not paid by a guaranty association or fund.

(3) Uninsured motorist coverage under Subsection 31A-22-302(1)(b) provides coverage for covered persons who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, disease, or death.

(4) (a) For new policies written on or after January 1, 2001, the limits of uninsured motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured 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 uninsured 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 no liability insurance; and

(v) discloses the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(b) Any selection or rejection under this Subsection (4) continues for that issuer of the liability coverage until the insured requests, in writing, a change of uninsured motorist coverage from that liability insurer.

(c) (i) Subsections (4)(a) and (b) 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 (4)(a) and (b) clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

(d) For purposes of this Subsection (4), "new policy" means:

(i) any policy that is issued which 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.

(e) (i) As used in this Subsection (4)(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 (4)(d).

(iii) If an additional motor vehicle is added to a personal lines policy where uninsured motorist coverage has been rejected, or where uninsured 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 as described in Subsection (4)(a)(iv), explains the purpose of uninsured 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 uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured 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 (4)(d)(ii) does not constitute a new policy.

(g) (i) Subsection (4)(d) 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 (4):

(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 uninsured motorist coverage in an amount that is less than its maximum self-insured retention under Subsections (4)(a) and (5)(a) 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 uninsured motorist claim.

(i) Uninsured motorist coverage may not be sold with limits that are less than the minimum bodily injury limits for motor vehicle liability policies under Section 31A-22-304.

(j) The acknowledgment under Subsection (4)(a) continues for that issuer of the uninsured motorist coverage until the named insured requests, in writing, different uninsured motorist coverage from the insurer.

(k) (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 uninsured motorist coverage in the same manner as described in Subsection (4)(a)(iv); and

(B) a disclosure of the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(ii) The disclosure required under Subsection (4)(k)(i) shall be sent to all named insureds that carry uninsured motorist coverage limits in an amount less than the named insured's motor vehicle liability policy limits or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(l) For purposes of this Subsection (4), a notice or disclosure sent to a named insured in a household constitutes notice or disclosure to all insureds within the household.

(5) (a) (i) Except as provided in Subsection (5)(b), the named insured may reject uninsured motorist coverage by an express writing to the insurer that provides liability coverage under Subsection 31A-22-302(1)(a).

(ii) This rejection shall be on a form provided by the insurer that includes a reasonable explanation of the purpose of uninsured motorist coverage.

(iii) This rejection continues for that issuer of the liability coverage until the insured in writing requests uninsured motorist coverage from that liability insurer.

(b) (i) All persons, including governmental entities, that are engaged in the business of, or that accept payment for, transporting natural persons by motor vehicle, and all school districts that provide transportation services for their students, shall provide coverage for all motor vehicles used for that purpose, by purchase of a policy of insurance or by self-insurance, uninsured motorist coverage of at least $25,000 per person and $500,000 per accident.

(ii) This coverage is secondary to any other insurance covering an injured covered person.

(c) Uninsured motorist coverage:

(i) is secondary to the benefits provided by Title 34A, Chapter 2, Workers' Compensation Act;

(ii) may not be subrogated by the workers' compensation insurance carrier;

(iii) may not be reduced by any benefits provided by workers' compensation insurance;

(iv) may be reduced by health insurance subrogation only after the covered person has been 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 (5)(c)(v), may be recovered:

(A) for a person under 18 years of age who is injured within the scope of Subsection (5)(c)(v) but 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.

(d) As used in this Subsection (5), "motor vehicle" has the same meaning as under Section 41-1a-102.

(6) When a covered person alleges that an uninsured motor vehicle under Subsection (2)(b) proximately caused an accident without touching the covered person or the motor vehicle occupied by the covered person, the covered person shall show the existence of the uninsured motor vehicle by clear and convincing evidence consisting of more than the covered person's testimony.

(7) (a) The limit of liability for uninsured 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.

(b) (i) Subsection (7)(a) applies to all persons except a covered person as defined under Subsection (8)(b)(ii).

(ii) A covered person as defined under Subsection (8)(b)(ii) is entitled to the highest limits of uninsured motorist coverage afforded for any one motor vehicle that the covered person is the named insured or an insured family member.

(iii) This coverage shall be in addition to the coverage on the motor vehicle the covered person is occupying.

(iv) Neither the primary nor the secondary coverage may be set off against the other.

(c) Coverage on a motor vehicle occupied at the time of an accident shall be primary coverage, and the coverage elected by a person described under Subsections (1)(a) [~~and~~], (b), and (c) shall be secondary coverage.

(8) (a) Uninsured motorist coverage under this section applies to bodily injury, sickness, disease, or death of covered persons while occupying or using a motor vehicle only if

the motor vehicle is described in the policy under which a claim is made, or if the motor vehicle is a newly acquired or replacement motor vehicle covered under the terms of the policy. Except as provided in Subsection (7) or this Subsection (8), a covered person injured in a motor vehicle described in a policy that includes uninsured motorist benefits may not elect to collect uninsured motorist coverage benefits from any other motor vehicle insurance policy under which the person is a covered person.

(b) Each of the following persons may also recover uninsured motorist benefits under any one other policy in which they are described as a "covered person" as defined in Subsection (1):

(i) a covered person injured as a pedestrian by an uninsured motor vehicle; and

(ii) except as provided in Subsection (8)(c), a covered person injured while occupying or using a motor vehicle that is not owned, leased, or furnished:

(A) to the covered person;

(B) to the covered person's spouse; or

(C) to the covered person's resident parent or resident sibling.

(c) (i) 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:

(A) a dependent minor of parents who reside in separate households; and

(B) injured while occupying or using a motor vehicle that is not owned, leased, or furnished:

(I) to the covered person;

(II) to the covered person's resident parent; or

(III) to the covered person's resident sibling.

(ii) Each parent's policy under this Subsection (8)(c) is liable only for the percentage of the damages that the limit of liability of each parent's policy of uninsured motorist coverage bears to the total of both parents' uninsured coverage applicable to the accident.

(d) A covered person's recovery under any available policies may not exceed the full amount of damages.

(e) A covered person in Subsection (8)(b) is not barred against making subsequent elections if recovery is unavailable under previous elections.

(f) (i) As used in this section, "interpolicy stacking" means recovering benefits for a single incident of loss under more than one insurance policy.

(ii) Except to the extent permitted by Subsection (7) and this Subsection (8), interpolicy stacking is prohibited for uninsured motorist coverage.

(9) (a) When a claim is brought by a named insured or a person described in Subsection (1) and is asserted against the covered person's uninsured 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 uninsured benefits are claimed, the election provided in Subsection (9)(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 (9)(a)(ii).

(c) Once the claimant has elected to commence litigation under Subsection (9)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the uninsured motorist carrier.

(d) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (9)(a)(i) shall be resolved by a single arbitrator.

(ii) All parties shall agree on the single arbitrator selected under Subsection (9)(d)(i).

(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (9)(d)(ii), the parties shall select a panel of three arbitrators.

(e) If the parties select a panel of three arbitrators under Subsection (9)(d)(iii):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (9)(e)(i) shall select one additional arbitrator to be included in the panel.

(f) 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 (9)(d)(i); or

(ii) if an arbitration panel is selected under Subsection (9)(d)(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 (9)(e)(ii).

(g) Except as otherwise provided in this section or unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section shall be governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

(h) (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 (10)(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 (10)(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.

(i) All issues of discovery shall be resolved by the arbitrator or the arbitration panel.

(j) A written decision by a single arbitrator or by a majority of the arbitration panel shall constitute a final decision.

(k) (i) Except as provided in Subsection (10), the amount of an arbitration award may not exceed the uninsured motorist policy limits of all applicable uninsured motorist policies, including applicable uninsured motorist umbrella policies.

(ii) If the initial arbitration award exceeds the uninsured motorist policy limits of all applicable uninsured motorist policies, the arbitration award shall be reduced to an amount equal to the combined uninsured motorist policy limits of all applicable uninsured motorist policies.

(l) The arbitrator or arbitration panel may not decide the issues 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) any allegations or claims asserting consequential damages or bad faith liability.

(m) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(n) If the arbitrator or arbitration panel finds that the action was 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 claim in good faith.

(o) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (9)(l) between the parties unless:

(i) the award was procured by corruption, fraud, or other undue means;

(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 (9)(o)(ii)(A).

(p) (i) Upon filing a complaint for a trial de novo under Subsection (9)(o), the 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 (9)(o)(ii)(A).

(q) (i) If the claimant, as the moving party in a trial de novo requested under Subsection (9)(o), 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 uninsured motorist carrier, as the moving party in a trial de novo requested under Subsection (9)(o), does not obtain a verdict that is at least 20% less than the arbitration award, the uninsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (9)(q)(iv), the costs under this Subsection (9)(q) 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 (9)(q) may not exceed $2,500 unless Subsection (10)(h)(iii) applies.

(r) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (9)(q), 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.

(s) If a district court determines, upon a motion of the nonmoving party, that the moving party's use of the trial de novo process was filed in bad faith in accordance with Section 78B-5-825, the district court may award reasonable attorney fees to the nonmoving party.

(t) Nothing in this section is intended to limit any claim under any other portion of an applicable insurance policy.

(u) If there are multiple uninsured motorist policies, as set forth in Subsection (8), the claimant may elect to arbitrate in one hearing the claims against all the uninsured motorist carriers.

(10) (a) Within 30 days after a covered person elects to submit a claim for uninsured motorist benefits to binding arbitration or files litigation, the covered person shall provide to the uninsured motorist carrier:

(i) a written demand for payment of uninsured motorist coverage benefits, setting forth:

(A) subject to Subsection (10)(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 the 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 uninsured motorist benefits are sought for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) [~~whether the covered person has seen other~~] 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 uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised that have not been disclosed under Subsection (10)(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 uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) [~~whether the identity of any~~] 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 uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured 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 uninsured 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 uninsured motorist carrier to only obtain records and billings from the individuals or entities disclosed <u>under Subsections (10)(a)(ii)(A)(I), (B)(I), and (C)</u>.

(b) (i) If the uninsured motorist carrier determines that the disclosure of undisclosed health care providers or health care insurers under Subsection (10)(a)(ii) is reasonably necessary, the uninsured 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 uninsured 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 uninsured 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 (10)(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 uninsured motorist carrier that receives an election for arbitration or a notice of filing litigation and the demand for payment of uninsured motorist benefits under Subsection (10)(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 (10)(a)(i) through (iii), to:

(A) provide a written response to the written demand for payment provided for in Subsection (10)(a)(i);

(B) except as provided in Subsection (10)(c)(i)(C), tender the amount, if any, of the uninsured 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 uninsured 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 uninsured motorist carrier under Subsection (10)(c)(i) is the total amount of the uninsured motorist policy limits, the tendered amount shall be accepted by the covered person.

(d) A covered person who receives a written response from an uninsured motorist carrier as provided for in Subsection (10)(c)(i), may:

(i) elect to accept the amount tendered in Subsection (10)(c)(i) as payment in full of all uninsured motorist claims; or

(ii) elect to:

(A) accept the amount tendered in Subsection (10)(c)(i) as partial payment of all uninsured motorist claims; and

(B) continue to litigate or arbitrate the remaining claim in accordance with the election made under Subsections (9)(a), (b), and (c).

(e) If a covered person elects to accept the amount tendered under Subsection (10)(c)(i) as partial payment of all uninsured motorist claims, the final award obtained through arbitration, litigation, or later settlement shall be reduced by any payment made by the uninsured motorist carrier under Subsection (10)(c)(i).

(f) In an arbitration proceeding on the remaining uninsured claims:

(i) the parties may not disclose to the arbitrator or arbitration panel the amount paid under Subsection (10)(c)(i) until after the arbitration award has been rendered; and

(ii) the parties may not disclose the amount of the limits of uninsured 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 (10)(a)(i) and the uninsured motorist carrier's initial written response provided for in Subsection (10)(c)(i), the uninsured 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 uninsured 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 uninsured 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 (10)(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 uninsured motorist coverage benefits to binding arbitration or files litigation as specified in Subsection (10)(a).

(ii) If the information under Subsection (10)(i)(i) is not disclosed, the covered person may not recover costs or any amounts in excess of the policy under Subsection (10)(g).

(j) This Subsection (10) does not limit any other cause of action that arose or may arise against the uninsured motorist carrier from the same dispute.

(k) The provisions of this Subsection (10) only apply to motor vehicle accidents that occur on or after March 30, 2010.

(l) (i) The written demand requirement in Subsection (10)(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 this bill to this Subsection (10)(l) and Subsection (10)(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 this bill to Subsections (10)(a)(ii)(A)(II) and (B)(II) apply to any claim submitted to binding arbitration or through litigation on or after May 13, 2014.

Section 12. 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); or

(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 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.

(b) Any selection or rejection under Subsection (3)(a) continues for that issuer of the liability coverage until the insured requests, in writing, a change of underinsured motorist coverage from that liability insurer.

(c) (i) Subsections (3)(a) and (b) 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)(a) and (b) clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

(d) For purposes of this Subsection (3), "new policy" means:

(i) any policy that is issued which 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.

(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)(d).

(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)(a)(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)(d)(ii) does not constitute a new policy.

(g) (i) Subsection (3)(d) 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)(d):

(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)(a) 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)(a) 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)(a)(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) Except as provided in Subsection (4)(b)(ii), 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.

(ii) (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)(ii) 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.

(iii) A covered person's recovery under any available policies may not exceed the full amount of damages.

(iv) 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) [~~and~~], (b), and (c) is secondary coverage.

(v) The primary and the secondary coverage may not be set off against the other.

(vi) A covered person as described under Subsection (4)(b)(i) 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.

(vii) A covered injured person is not barred against making subsequent elections if recovery is unavailable under previous elections.

(viii) (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) is secondary to the benefits provided by Title 34A, Chapter 2, Workers' Compensation Act;

(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 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) (a) Within five business days after notification that all liability insurers have tendered their liability policy limits, the underinsured carrier shall either:

(i) waive any subrogation claim the underinsured carrier may have against the person liable for the injuries caused in the accident; or

(ii) pay the insured an amount equal to the policy limits tendered by the liability carrier.

(b) If neither option is exercised under Subsection (6)(a), the subrogation claim is considered to be waived by the underinsured carrier.

(c) The notification under Subsection (6)(a) shall include:

(i) the name, address, and phone number for all liability insurers;

(ii) the liability insurers' liability policy limits; and

(iii) the claim number associated with each liability insurer.

(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) (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)(d)(i).

(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (8)(d)(ii), the parties shall select a panel of three arbitrators.

(e) If the parties select a panel of three arbitrators under Subsection (8)(d)(iii):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (8)(e)(i) shall select one additional arbitrator to be included in the panel.

(f) 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)(d)(i); or

(ii) if an arbitration panel is selected under Subsection (8)(d)(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)(e)(ii).

(g) 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.

(h) (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.

(i) An issue of discovery shall be resolved by the arbitrator or the arbitration panel.

(j) A written decision by a single arbitrator or by a majority of the arbitration panel constitutes a final decision.

(k) (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.

(l) 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.

(m) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(n) 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.

(o) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (8)(l) between the parties unless:

(i) the award is procured by corruption, fraud, or other undue means;

(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)(o)(ii)(A).

(p) (i) Upon filing a complaint for a trial de novo under Subsection (8)(o), 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)(o)(ii)(A).

(q) (i) If the claimant, as the moving party in a trial de novo requested under Subsection (8)(o), 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)(o), 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)(q)(iv), the costs under this Subsection (8)(q) 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)(q) may not exceed $2,500 unless Subsection (9)(h)(iii) applies.

(r) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (8)(q), 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.

(s) 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.

(t) Nothing in this section is intended to limit a claim under another portion of an applicable insurance policy.

(u) 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) [~~whether the covered person has seen other~~] the names and last know 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) [~~whether the identity of any~~] 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 <u>under Subsections (9)(a)(ii)(A)(I), (B)(I), and (C)</u>.

(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) <u>continue to</u> litigate or arbitrate the remaining claim <u>in accordance with the election made under Subsections (8)(a), (b), and (c)</u>.

(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 this bill 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 this bill 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 13. Section **31A-22-428** is amended to read:

31A-22-428. Interest payable on life insurance proceeds.

(1) For a life insurance policy delivered or issued for delivery in this state on or after May 5, 2008, the insurer shall pay interest on the death proceeds payable upon the death of the insured.

(2) (a) Except as provided in Subsection (4), for the period beginning on the date of death and ending the day before the day described in Subsection (3)(b), interest under Subsection (1) shall accrue at a rate no less than the greater of:

(i) the rate applicable to policy funds left on deposit; [~~or~~] and

(ii) [~~if there is no rate described in Subsection (2)(a)(i), at~~] the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve.

(b) If there is no rate applicable to policy funds on deposit as stated in Subsection

(2)(a)(i), then the Two Year Treasury Constant Maturity Rates as published by the Federal Reserve applies.

[~~(b)~~] (c) The rate described in Subsection (2)(a) or (b) is the rate in effect on the day on which the death occurs.

[~~(c)~~] (d) Interest is payable until the day on which the claim is paid.

(3) (a) Unless the claim is paid and except as provided in Subsection (4), beginning on the day described in Subsection (3)(b) and ending the day on which the claim is paid, interest shall accrue at the rate in Subsection (2) plus additional interest at the rate of 10% annually.

(b) Interest accrues under Subsection (3)(a) beginning with the day that is 31 days from the latest of:

(i) the day on which the insurer receives proof of death;

(ii) the day on which the insurer receives sufficient information to determine:

(A) liability;

(B) the extent of the liability; and

(C) the appropriate payee legally entitled to the proceeds; and

(iii) the day on which:

(A) legal impediments to payment of proceeds that depend on the action of parties other than the insurer are resolved; and

(B) the insurer receives sufficient evidence of the resolution of the legal impediments described in Subsection (3)(b)(iii)(A).

(4) A court of competent jurisdiction may require payment of interest from the date of death to the day on which a claim is paid at a rate equal to the sum of:

(a) the rate specified in Subsection (2); and

(b) the legal rate identified in Subsection 15-1-1(2).

Section 14. Section **31A-22-617** is amended to read:

31A-22-617. Preferred provider contract provisions.

Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows:

(1) Subject to restrictions under this section, [~~any~~] an insurer or third party administrator may enter into contracts with health care providers as defined in Section 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.

(a) (i) A health care provider contract may require the health care provider to accept the specified payment in this Subsection (1) as payment in full, relinquishing the right to collect additional amounts from the insured person.

(ii) In [~~any~~] a dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer's written payment policies in effect at the time services were rendered.

(iii) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(v) If an insurer permits another entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks of participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network.

(b) The insurance contract may reward the insured for selection of preferred health care providers by:

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;

(iv) other copayments; or

(v) any other reasonable manner.

(c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(1)(f):

(i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

(A) require the health care provider to continue to provide health care services under the contract until the earlier of:

(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);

(ii) the provider is required to:

(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);

(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the [~~language required by~~] requirements described in Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

(A) sums owed by the insolvent managed care organization; or

(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

(iv) the following may not bill or maintain [~~any~~] an action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):

(A) a provider;

(B) an agent;

(C) a trustee; or

(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and

(v) notwithstanding Subsection (1)(c)(i):

(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and

(B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of:

(I) a petition for rehabilitation; or

(II) a petition for liquidation.

(2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on or after January 1, 2014.

(b) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

(c) An insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

(d) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

(e) For purposes of this section, unfair discrimination between classes of health care providers includes:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly used by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the insurer; and

(C) within the scope of practice of the class of health care providers.

(3) Before the insured consents to the insurance contract, the insurer shall fully disclose to the insured that it has entered into preferred health care provider contracts. The insurer shall provide sufficient detail on the preferred health care provider contracts to permit the insured to agree to the terms of the insurance contract. The insurer shall provide at least the following information:

(a) a list of the health care providers under contract, and if requested their business locations and specialties;

(b) a description of the insured benefits, including [~~any~~] deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (4); and

(d) a description of the adverse benefit determination procedures required under Subsection (5).

(4) (a) An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provided by the health care providers under contract meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the organization and its health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

(5) An insurer using preferred health care provider contracts shall provide a reasonable

procedure for resolving complaints and adverse benefit determinations initiated by the insureds and health care providers.

(6) An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.

(7) (a) A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

(b) [~~Any~~] A health care provider licensed to treat [~~any~~] an illness or injury within the scope of the health care provider's practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and receive the designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

(8) Upon the written request of a provider excluded from a provider contract, the commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based on the criteria set forth in Subsection (7)(b).

[~~(9) Except as provided in Subsection 31A-22-618.5(3)(a), insurers are subject to Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.~~]

[~~(10)~~] (9) Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan.

[~~(11)~~] (10) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

[~~(12)~~] (11) Notwithstanding [~~the provisions of~~] Subsection (1), Subsection (7)(b), and Section 31A-22-618, an insurer or third party administrator is not required to, but may, enter into [~~contracts~~] a contract with a licensed athletic [~~trainers~~] trainer, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

Section 15. Section **31A-22-618.5** is amended to read:

31A-22-618.5. Health benefit plan offerings.

(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may offer to a potential purchaser one or more health benefit plans that:

(i) are not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

(B) the limitation on point of service products in Subsections 31A-8-408(3) through (6);

(C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or

(D) coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627 as follows:

(A) within the organization's service area, covered services shall include health care services from nonaffiliated providers when medically necessary to stabilize an emergency medical condition; and

(B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) [~~notwithstanding Subsection 31A-22-617(9),~~] may offer a health benefit plan that is not subject to Section 31A-22-618;

(b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627; and

(c) is not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5) (a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.

(b) Any difference in price between a health benefit plan offered under Subsection (3)(a) shall be based on actuarially sound data.

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Section 16. Section **31A-22-625** is amended to read:

31A-22-625. Catastrophic coverage of mental health conditions.

(1) As used in this section:

(a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, before reaching a maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b) (i) "50/50 mental health coverage" means coverage in a health benefit plan that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on:

(A) episodic limits;

(B) inpatient or outpatient service limits; or

(C) maximum out-of-pocket limits.

(c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(d) (i) "Mental health condition" means a condition or disorder involving mental illness that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) a marital or family problem;

(B) a social, occupational, religious, or other social maladjustment;

(C) a conduct disorder;

(D) a chronic adjustment disorder;

(E) a psychosexual disorder;

(F) a chronic organic brain syndrome;

(G) a personality disorder;

(H) a specific developmental disorder or learning disability; or

(I) an intellectual disability.

(e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(2) (a) At the time of purchase and renewal, an insurer shall offer to a small employer that it insures or seeks to insure a choice between:

(i) (A) catastrophic mental health coverage; or

(B) federally qualified mental health coverage as described in Subsection (3); and

(ii) 50/50 mental health coverage.

(b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, regardless of the employer's previous coverage for mental health conditions, choose either:

(i) coverage offered under Subsection (2)(a)(i);

(ii) 50/50 mental health coverage; or

(iii) coverage offered under Subsection (2)(b).

(d) An insurer is exempt from the 30% index rating restriction in Section 31A-30-106.1 and, for the first year only that the employer chooses coverage that meets or exceeds catastrophic mental health coverage, the 15% annual adjustment restriction in Section 31A-30-106.1, for [~~any~~] a small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3) (a) An insurer shall offer a large employer mental health and substance use disorder benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.

(b) An insurer shall provide in an individual or small employer health benefit plan, mental health and substance use disorder benefits in compliance with Sections 2705 and 2711 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.

(4) (a) An insurer may provide catastrophic mental health coverage to a small employer through a managed care organization or system in a manner consistent with Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the insurance policy uses a managed care organization or system for the treatment of physical health

conditions.

(b) (i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.

(iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition shall be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility:

(A) licensed or otherwise authorized to provide mental health services pursuant to:

(I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and

(B) that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may prohibit an insurance policy that provides mental health coverage in a manner that is inconsistent with this section.

(6) The commissioner [~~shall: (a)~~] may adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this

section[~~; and~~].

[~~(b) provide general figures on the percentage of insurance policies that include:~~]

[~~(i) no mental health coverage;~~]

[~~(ii) 50/50 mental health coverage;~~]

[~~(iii) catastrophic mental health coverage; and~~]

[~~(iv) coverage that exceeds the minimum requirements of this section.~~]

[~~(7) This section may not be construed as discouraging or otherwise preventing an insurer from providing mental health coverage in connection with an individual insurance policy.~~]

Section 17. Section **31A-22-635** is amended to read:

31A-22-635. Uniform application -- Uniform waiver of coverage -- Information on Health Insurance Exchange.

(1) For purposes of this section, "insurer":

(a) is defined in Subsection 31A-22-634(1); and

(b) includes the state employee's risk pool under Section 49-20-202.

(2) (a) Insurers offering a health benefit plan to an individual or small employer shall use a uniform application form.

(b) The uniform application form:

(i) [~~except for cancer and transplants,~~] may not include questions about an applicant's health history [~~prior to the previous five years~~]; and

(ii) shall be shortened and simplified in accordance with rules adopted by the commissioner.

(c) Insurers offering a health benefit plan to a small employer shall use a uniform waiver of coverage form, which may not include health status related questions [~~other than pregnancy~~], and is limited to:

(i) information that identifies the employee;

(ii) proof of the employee's insurance coverage; and

(iii) a statement that the employee declines coverage with a particular employer group.

(3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may, if the combination or modification is approved by the commissioner, be combined or modified to facilitate a more efficient and consumer friendly experience for:

(a) enrollees using the Health Insurance Exchange; or

(b) insurers using electronic applications.

(4) The uniform application form, and uniform waiver form, shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(5) (a) An insurer who offers a health benefit plan [~~in either the group or individual market~~] on the Health Insurance Exchange created in Section 63M-1-2504, shall:

(i) accept and process an electronic submission of the uniform application or uniform waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to Section 63M-1-2506;

(ii) if requested, provide the applicant with a copy of the completed application either by mail or electronically;

(iii) post all health benefit plans offered by the insurer in the defined contribution arrangement market on the Health Insurance Exchange; and

(iv) post the information required by Subsection (6) on the Health Insurance Exchange for every health benefit plan the insurer offers on the Health Insurance Exchange.

(b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans on the Health Insurance Exchange may not directly or indirectly offer products on the Health Insurance Exchange that are not health benefit plans.

(c) Notwithstanding Subsection (5)(b):

(i) an insurer may offer a health savings account on the Health Insurance Exchange; [~~and~~]

(ii) an insurer may offer dental [~~and vision~~] plans on the Health Insurance Exchange [~~if:~~]<u>; and</u>

[~~(A) the department determines, after study and consultation with the Health System Reform Task Force, that the department is able to establish standards for dental and vision policies offered on the Health Insurance Exchange, and the department determines whether a risk adjuster mechanism is necessary for a defined contribution vision and dental plan market on the Health Insurance Exchange; and~~]

[~~(B)~~] (iii) the department[~~, in accordance with recommendations from the Health System Reform Task Force, adopts~~] may make administrative rules to regulate the offer of dental [~~and vision~~] plans on the Health Insurance Exchange.

(6) An insurer shall provide the commissioner and the Health Insurance Exchange with the following information for each health benefit plan submitted to the Health Insurance Exchange, in the electronic format required by Subsection 63M-1-2506(1):

(a) plan design, benefits, and options offered by the health benefit plan including state mandates the plan does not cover;

(b) information and Internet address to online provider networks;

(c) wellness programs and incentives;

(d) descriptions of prescription drug benefits, exclusions, or limitations;

(e) the percentage of claims paid by the insurer within 30 days of the date a claim is submitted to the insurer for the prior year; and

(f) the claims denial and insurer transparency information developed in accordance with Subsection 31A-22-613.5(4).

(7) The department shall post on the Health Insurance Exchange the department's solvency rating for each insurer who posts a health benefit plan on the Health Insurance Exchange. The solvency rating for each insurer shall be based on methodology established by the department by administrative rule and shall be updated each calendar year.

(8) (a) The commissioner may request information from an insurer under Section 31A-22-613.5 to verify the data submitted to the department and to the Health Insurance Exchange.

(b) The commissioner shall regulate [~~any~~] the fees charged by insurers to an enrollee for a uniform application form or electronic submission of the application forms.

Section 18. Section **31A-22-721** is amended to read:

31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and nonrenewal.

(1) Except as otherwise provided in this section, a health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

(a) for a network plan, if[~~: (i)~~] there is no longer any enrollee under the group health plan who lives, resides, or works in:

[~~(A)~~] (i) the service area of the insurer; or

[~~(B)~~] (ii) the area for which the insurer is authorized to do business; [~~and~~] or

[~~(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or~~]

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A health benefit plan for a plan sponsor may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state;

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any other health benefit products currently being offered:

(I) by the insurer in the market; or

(II) in the case of a large employer, any other health benefit plan currently being offered in that market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, the insurer acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to a new participant or beneficiary who may become eligible for coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans:

(A) in the small employer market; or

(B) the large employer market; or

(C) both the small and large employer markets; and

(ii) (A) provides notice of the discontinuance in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 business days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of a plan sponsor or employee;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A large employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's employer contribution requirements.

(6) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's minimum participation requirements.

(7) (a) Except as provided in Subsection (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (7) because of a fraud or misrepresentation that relates to health status.

(8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new business in such market in this state for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(b) The commissioner may waive the prohibition under Subsection (8)(a) when the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(9) If an insurer is doing business in one established geographic service area of the state, this section applies only to the insurer's operations in that geographic service area.

(10) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with a particular product or service.

(11) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the health benefit plan is made available by an insurer in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(12) (a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the small group market.

(b) A large employer that, after purchasing a health benefit plan in the large group market, employs on average less than 51 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the large group market.

(13) An insurer offering employer sponsored health benefit plans shall comply with the Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.

Section 19. Section **31A-23a-102** is amended to read:

31A-23a-102. Definitions.

As used in this chapter:

(1) "Bail bond producer" is as defined in Section 31A-35-102.

(2) "Home state" means a state or territory of the United States or the District of Columbia in which an insurance producer:

(a) maintains the insurance producer's principal:

(i) place of residence; or

(ii) place of business; and

(b) is licensed to act as an insurance producer.

(3) "Insurer" is as defined in Section 31A-1-301, except that the following persons or similar persons are not insurers for purposes of Part 7, Producer Controlled Insurers:

(a) a risk retention group as defined in:

(i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;

(ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and

(iii) Chapter 15, Part 2, Risk Retention Groups Act;

(b) a residual market pool;

(c) a joint underwriting authority or association; and

(d) a captive insurer.

(4) "License" is defined in Section 31A-1-301.

(5) (a) "Managing general agent" means a person that:

(i) manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office;

(ii) acts as an agent for the insurer whether it is known as a managing general agent, manager, or other similar term;

(iii) produces and underwrites an amount of gross direct written premium equal to, or more than, 5% of[;] the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year:

(A) with or without the authority;

(B) separately or together with an affiliate; and

(C) directly or indirectly; and

(iv) (A) adjusts or pays claims in excess of an amount determined by the commissioner; or

(B) negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding Subsection (5)(a), the following persons may not be considered as managing general agent for the purposes of this chapter:

(i) an employee of the insurer;

(ii) a United States manager of the United States branch of an alien insurer;

(iii) an underwriting manager that, pursuant to contract:

(A) manages all the insurance operations of the insurer;

(B) is under common control with the insurer;

(C) is subject to Chapter 16, Insurance Holding Companies; and

(D) is not compensated based on the volume of premiums written; and

(iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

(6) "Negotiate" means the act of conferring directly with or offering advice directly to a

purchaser or prospective purchaser of a particular contract of insurance concerning a substantive benefit, term, or condition of the contract if the person engaged in that act:

(a) sells insurance; or

(b) obtains insurance from insurers for purchasers.

(7) "Reinsurance intermediary" means:

(a) a reinsurance intermediary-broker; or

(b) a reinsurance intermediary-manager.

(8) "Reinsurance intermediary-broker" means a person other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

(9) (a) "Reinsurance intermediary-manager" means a person who:

(i) has authority to bind or who manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office; and

(ii) acts as an agent for the reinsurer whether the person is known as a reinsurance intermediary-manager, manager, or other similar term.

(b) Notwithstanding Subsection (9)(a), the following persons may not be considered reinsurance intermediary-managers for the purpose of this chapter with respect to the reinsurer:

(i) an employee of the reinsurer;

(ii) a United States manager of the United States branch of an alien reinsurer;

(iii) an underwriting manager that, pursuant to contract:

(A) manages all the reinsurance operations of the reinsurer;

(B) is under common control with the reinsurer;

(C) is subject to Chapter 16, Insurance Holding Companies; and

(D) is not compensated based on the volume of premiums written; and

(iv) the manager of a group, association, pool, or organization of insurers that:

(A) engage in joint underwriting or joint reinsurance; and

(B) are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

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

[~~(10)~~] (11) "Search" means a license subline of authority in conjunction with the title insurance line of authority that allows a person to issue title insurance commitments or policies on behalf of a title insurer.

[~~(11)~~] (12) "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.

[~~(12)~~] (13) "Solicit" means:

(a) attempting to sell insurance;

(b) asking or urging a person to apply for:

(i) a particular kind of insurance; and

(ii) insurance from a particular insurance company;

(c) advertising insurance, including advertising for the purpose of obtaining leads for the sale of insurance; or

(d) holding oneself out as being in the insurance business.

[~~(13)~~] (14) "Terminate" means:

(a) the cancellation of the relationship between:

(i) an individual licensee or agency licensee and a particular insurer; or

(ii) an individual licensee and a particular agency licensee; or

(b) the termination of:

(i) an individual licensee's or agency licensee's authority to transact insurance on behalf of a particular insurance company; or

(ii) an individual licensee's authority to transact insurance on behalf of a particular agency licensee.

[~~(14)~~] (15) "Title marketing representative" means a person who:

(a) represents a title insurer in soliciting, requesting, or negotiating the placing of:

(i) title insurance; or

(ii) escrow services; and

(b) does not have a search or escrow license as provided in Section 31A-23a-106.

[~~(15)~~] (16) "Uniform application" means the version of the National Association of Insurance Commissioners' uniform application for resident and nonresident producer licensing at the time the application is filed.

[~~(16)~~] (17) "Uniform business entity application" means the version of the National Association of Insurance Commissioners' uniform business entity application for resident and nonresident business entities at the time the application is filed.

Section 20. Section **31A-23a-104** is amended to read:

31A-23a-104. Application for individual license -- Application for agency license.

(1) This section applies to an initial or renewal license as a:

(a) producer;

(b) surplus lines producer;

(c) limited line producer;

(d) consultant;

(e) managing general agent; or

(f) reinsurance intermediary.

(2) (a) Subject to Subsection (2)(b), to obtain or renew an individual license, an individual shall:

(i) file an application for an initial or renewal individual license with the commissioner on forms and in a manner the commissioner prescribes; and

(ii) pay a license fee that is not refunded if the application:

(A) is denied; or

(B) is incomplete when filed and is never completed by the applicant.

(b) An application described in this Subsection (2) shall provide:

(i) information about the applicant's identity;

(ii) the applicant's Social Security number;

(iii) the applicant's personal history, experience, education, and business record;

(iv) whether the applicant is 18 years of age or older;

(v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23a-105 or 31A-23a-111;

(vi) if the application is for a resident individual producer license, certification that the applicant complies with Section 31A-23a-203.5; and

(vii) any other information the commissioner reasonably requires.

(3) The commissioner may require a document reasonably necessary to verify the information contained in an application filed under this section.

(4) An applicant's Social Security number contained in an application filed under this section is a private record under Section 63G-2-302.

(5) (a) Subject to Subsection (5)(b), to obtain or renew an agency license, a person shall:

(i) file an application for an initial or renewal agency license with the commissioner on forms and in a manner the commissioner prescribes; and

(ii) pay a license fee that is not refunded if the application:

(A) is denied; or

(B) is incomplete when filed and is never completed by the applicant.

(b) An application described in Subsection (5)(a) shall provide:

(i) information about the applicant's identity;

(ii) the applicant's federal employer identification number;

(iii) the designated responsible licensed [~~producer~~] individual;

(iv) the identity of the owners, partners, officers, and directors;

(v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23a-105 or 31A-23a-111; and

(vi) any other information the commissioner reasonably requires.

Section 21. Section **31A-23a-105** is amended to read:

31A-23a-105. General requirements for individual and agency license issuance and renewal.

(1) (a) The commissioner shall issue or renew a license to a person described in Subsection (1)(b) to act as:

(i) a producer;

(ii) a surplus lines producer;

(iii) a limited line producer;

(iv) a consultant;

(v) a managing general agent; or

(vi) a reinsurance intermediary.

(b) The commissioner shall issue or renew a license under Subsection (1)(a) to a person who, as to the license type and line of authority classification applied for under Section 31A-23a-106:

(i) satisfies the application requirements under Section 31A-23a-104;

(ii) satisfies the character requirements under Section 31A-23a-107;

(iii) satisfies [~~any~~] applicable continuing education requirements under Section 31A-23a-202;

(iv) satisfies [~~any~~] applicable examination requirements under Section 31A-23a-108;

(v) satisfies [~~any~~] applicable training period requirements under Section 31A-23a-203;

(vi) if an applicant for a resident individual producer license, certifies that, to the extent applicable, the applicant:

(A) is in compliance with Section 31A-23a-203.5; and

(B) will maintain compliance with Section 31A-23a-203.5 during the period for which the license is issued or renewed;

(vii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23a-111;

(viii) if a nonresident:

(A) complies with Section 31A-23a-109; and

(B) holds an active similar license in that person's home state [~~of residence~~];

(ix) if an applicant for an individual title insurance producer or agency title insurance producer license, satisfies the requirements of Section 31A-23a-204;

(x) if an applicant for a license to act as a life settlement provider or life settlement producer, satisfies the requirements of Section 31A-23a-117; and

(xi) pays the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for a pending:

(A) individual or agency producer license;

(B) surplus lines producer license;

(C) limited line producer license;

(D) consultant license;

(E) managing general agent license; or

(F) reinsurance intermediary license; or

(ii) a licensed:

(A) individual or agency producer;

(B) surplus lines producer;

(C) limited line producer;

(D) consultant;

(E) managing general agent; or

(F) reinsurance intermediary.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) an administrative action taken against the person, including a denial of a new or renewal license application:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) a criminal prosecution taken against the person in any jurisdiction.

(c) The report required by Subsection (2)(b) shall:

(i) be filed:

(A) at the time the person files the application for an individual or agency license; and

(B) for an action or prosecution that occurs on or after the day on which the person files the application:

(I) for an administrative action, within 30 days of the final disposition of the administrative action; or

(II) for a criminal prosecution, within 30 days of the initial appearance before a court; and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).

(3) (a) The department may require a person applying for a license or for consent to engage in the business of insurance to submit to a criminal background check as a condition of receiving a license or consent.

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(d) Information obtained by the department from the review of criminal history records received under this Subsection (3) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-23a-107 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-23a-107; and

(iii) preventing a person who violates the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in the state.

(e) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(c)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(c)(ii); and

(iii) charge the person applying for a license or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).

(4) To become a resident licensee in accordance with Section 31A-23a-104 and this section, a person licensed as one of the following in another state who moves to this state shall apply within 90 days of establishing legal residence in this state:

(a) insurance producer;

(b) surplus lines producer;

(c) limited line producer;

(d) consultant;

(e) managing general agent; or

(f) reinsurance intermediary.

(5) (a) The commissioner may deny a license application for a license listed in Subsection (5)(b) if the person applying for the license, as to the license type and line of

authority classification applied for under Section 31A-23a-106:

(i) fails to satisfy the requirements as set forth in this section; or

(ii) commits an act that is grounds for denial, suspension, or revocation as set forth in Section 31A-23a-111.

(b) This Subsection (5) applies to the following licenses:

(i) producer;

(ii) surplus lines producer;

(iii) limited line producer;

(iv) consultant;

(v) managing general agent; or

(vi) reinsurance intermediary.

(6) Notwithstanding the other provisions of this section, the commissioner may:

(a) issue a license to an applicant for a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission; and

(b) renew a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission.

Section 22. Section **31A-23a-108** is amended to read:

31A-23a-108. Examination requirements.

(1) (a) The commissioner may require [~~applicants~~] an applicant for [~~any~~] a particular license type under Section 31A-23a-106 to pass a line of authority examination as a requirement for a license, except that an examination may not be required of [~~applicants~~] an applicant for:

(i) [~~licenses~~] a license under Subsection 31A-23a-106(2)(c); or

(ii) [~~other~~] another limited line license [~~lines~~] line of authority recognized by the commissioner or the Title and Escrow Commission by rule as provided in Subsection 31A-23a-106(3).

(b) The examination described in Subsection (1)(a):

(i) shall reasonably relate to the line of authority for which it is prescribed; and

(ii) may be administered by the commissioner or as otherwise specified by rule.

(2) The commissioner shall waive the requirement of an examination for a nonresident applicant who:

(a) applies for an insurance producer license in this state within 90 days of establishing legal residence in this state;

(b) has been licensed for the same line of authority in another state; and

(c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant applies for an insurance producer license in this state; or

(ii) if the application is received within 90 days of the cancellation of the applicant's previous license:

(A) the prior state certifies that at the time of cancellation, the applicant was in good standing in that state; or

(B) the state's producer database records maintained by the National Association of Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority requested.

[~~(3) A nonresident producer licensee who moves to this state and applies for a resident license within 90 days of establishing legal residence in this state shall be exempt from any line of authority examination that the producer was authorized on the producer's nonresident producer license, except where the commissioner determines otherwise by rule.~~]

[~~(4)~~] (3) This section's requirement may only be applied to [~~applicants who are natural persons~~] an applicant who is a natural person.

Section 23. Section **31A-23a-112** is amended to read:

31A-23a-112. Probation -- Grounds for revocation.

(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:

(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for [~~any~~] circumstances that would justify a suspension under Section

31A-23a-111; or

(b) at the issuance or renewal of a [~~new~~] license:

(i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or

(ii) with a response to background information questions on a new or renewal license application [~~indicating that~~] or information received from a background check conducted in connection with a new or renewal license application that indicates:

(A) the person has been convicted of a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation;

(B) the person is currently charged with a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation regardless of whether adjudication is withheld;

(C) the person has been involved in an administrative proceeding regarding [~~any~~] a professional or occupational license; or

(D) [~~any~~] a business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding [~~any~~] a professional or occupational license.

(2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~].

(3) The probation order shall state the conditions for retention of the license, which shall be reasonable.

(4) [~~Any~~] A violation of the probation is grounds for revocation pursuant to [~~any~~] a proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Section 24. Section **31A-23a-113** is amended to read:

31A-23a-113. License lapse and voluntary surrender.

(1) (a) A license issued under this chapter shall lapse if the licensee fails to:

(i) pay when due a fee under Section 31A-3-103;

(ii) complete continuing education requirements under Section 31A-23a-202 before submitting the license renewal application;

(iii) submit a completed renewal application as required by Section 31A-23a-104;

(iv) submit additional documentation required to complete the licensing process as related to a specific license type or line of authority; or

(v) maintain an active license in a [~~resident~~] licensee's home state if the licensee is a nonresident licensee.

(b) (i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):

(A) military service;

(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or

(C) some other extenuating circumstances, such as long-term medical disability.

(ii) A licensee described in Subsection (1)(b)(i) may request:

(A) reinstatement of the license no later than one year after the day on which the license lapses; and

(B) waiver of any of the following imposed for failure to comply with renewal procedures:

(I) an examination requirement;

(II) reinstatement fees set under Section 31A-3-103;

(III) continuing education requirements; or

(IV) other sanction imposed for failure to comply with renewal procedures.

(2) If a license issued under this chapter is voluntarily surrendered, the license or line of authority may be reinstated:

(a) during the license period in which the license is voluntarily surrendered; and

(b) no later than one year after the day on which the license is voluntarily surrendered.

[~~(3) A voluntarily surrendered license that is reinstated during the license period set forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the~~

~~license complies with any applicable continuing education requirements for the period during which the license was voluntarily surrendered.~~]

Section 25. Section **31A-23a-202** is amended to read:

31A-23a-202. Continuing education requirements.

(1) Pursuant to this section, the commissioner shall by rule prescribe the continuing education requirements for a producer and a consultant.

(2) (a) The commissioner may not state a continuing education requirement in terms of formal education.

(b) The commissioner may state a continuing education requirement in terms of hours of insurance-related instruction received.

(c) Insurance-related formal education may be a substitute, in whole or in part, for the hours required under Subsection (2)(b).

(3) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (3).

(b) (i) Except as provided in this section, the continuing education requirements shall require:

(A) that a licensee complete 24 credit hours of continuing education for every two-year licensing period;

(B) that 3 of the 24 credit hours described in Subsection (3)(b)(i)(A) be ethics courses; and

(C) that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

(ii) An hour of continuing education in accordance with Subsection (3)(b)(i) may be obtained through:

(A) classroom attendance;

(B) home study;

(C) watching a video recording;

(D) experience credit; or

(E) another method provided by rule.

(iii) (A) Notwithstanding Subsections (3)(b)(i)(A) and (B), an individual title insurance producer is required to complete 12 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses unless the individual title insurance producer is licensed in this state as an individual title insurance producer for 20 or more consecutive years.

(B) If an individual title insurance producer is licensed in this state as an individual title insurance producer for 20 or more consecutive years, the individual title insurance producer is required to complete 6 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses.

(C) Notwithstanding Subsection (3)(b)(iii)(A) or (B), an individual title insurance producer is considered to have met the continuing education requirements imposed under Subsection (3)(b)(iii)(A) or (B) if the individual title insurance producer:

(I) is an active member in good standing with the Utah State Bar;

(II) is in compliance with the continuing education requirements of the Utah State Bar; and

(III) if requested by the department, provides the department evidence that the individual title insurance producer complied with the continuing education requirements of the Utah State Bar.

(c) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(d) (i) A licensee is exempt from continuing education requirements under this section if:

(A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before May 11, 2011;

(C) the licensee requests an exemption from the department; and

(D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (3)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall, by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(b);

(ii) authorize a continuing education provider or a state or national professional producer or consultant association to:

(A) offer a qualified program for a license type or line of authority on a geographically accessible basis; and

(B) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner; and

(iii) provide that membership by a producer or consultant in a state or national professional producer or consultant association is considered a substitute for the equivalent of two hours for each year during which the producer or consultant is a member of the professional association, except that the commissioner may not give more than two hours of continuing education credit in a year regardless of the number of professional associations of which the producer or consultant is a member.

(f) A fee permitted under Subsection (3)(e)(ii)(B) that is charged for attendance at a professional producer or consultant association program may be less for an association member, on the basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(4) The commissioner shall approve a continuing education provider or continuing education course that satisfies the requirements of this section.

(5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the

commissioner shall by rule set the processes and procedures for continuing education provider registration and course approval.

(6) The requirements of this section apply only to a producer or consultant who is an individual.

(7) A nonresident producer or consultant is considered to have satisfied this state's continuing education requirements if the nonresident producer or consultant satisfies the nonresident producer's or consultant's home state's continuing education requirements for a licensed insurance producer or consultant.

(8) A producer or consultant subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education applies.

Section 26. Section **31A-23a-203** is amended to read:

31A-23a-203. Training period requirements.

(1) A producer is eligible to become a surplus lines producer only if the producer:

(a) has passed the applicable surplus lines producer examination;

(b) has been a producer with property [~~and~~] or casualty or both lines of authority for at least three years during the four years immediately preceding the date of application; and

(c) has paid the applicable fee under Section 31A-3-103.

(2) A person is eligible to become a consultant only if the person has acted in a capacity that would provide the person with preparation to act as an insurance consultant for a period aggregating not less than three years during the four years immediately preceding the date of application.

(3) (a) A resident producer with an accident and health line of authority may only sell long-term care insurance if the producer:

(i) initially completes a minimum of three hours of long-term care training before selling long-term care coverage; and

(ii) after completing the training required by Subsection (3)(a)(i), completes a minimum of three hours of long-term care training during each subsequent two-year licensing period.

(b) A course taken to satisfy a long-term care training requirement may be used toward satisfying a producer continuing education requirement.

(c) Long-term care training is not a continuing education requirement to renew a producer license.

(d) An insurer that issues long-term care insurance shall demonstrate to the commissioner, upon request, that a producer who is appointed by the insurer and who sells long-term care insurance coverage is in compliance with this Subsection (3).

(4) The training periods required under this section apply only to an individual applying for a license under this chapter.

Section 27. Section **31A-23a-402.5** is amended to read:

31A-23a-402.5. Inducements.

(1) (a) Except as provided in Subsection (2), a producer, consultant, or other licensee under this title, or an officer or employee of a licensee, may not induce a person to enter into, continue, or terminate an insurance contract by offering a benefit that is not:

(i) specified in the insurance contract; or

(ii) directly related to the insurance contract.

(b) An insurer may not make or knowingly allow an agreement of insurance that is not clearly expressed in the insurance contract to be issued or renewed.

(c) A licensee under this title may not absorb the tax under Section 31A-3-301.

(2) This section does not apply to a title insurer, an individual title insurance producer, or agency title insurance producer, or an officer or employee of a title insurer, an individual title insurance producer, or an agency title insurance producer.

(3) Items not prohibited by Subsection (1) include an insurer:

(a) reducing premiums because of expense savings;

(b) providing to a policyholder or insured one or more incentives, as defined by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to participate in a program or activity designed to reduce claims or claim expenses, including:

(i) a premium discount offered to a small or large employer group based on a wellness program if:

(A) the premium discount for the employer group does not exceed 20% of the group premium; and

(B) the premium discount based on the wellness program is offered uniformly by the insurer to all employer groups in the large or small group market;

(ii) a premium discount offered to employees of a small or large employer group in an amount that does not exceed federal limits on wellness program incentives; or

(iii) a combination of premium discounts offered to the employer group and the employees of an employer group, based on a wellness program, if:

(A) the premium discounts for the employer group comply with Subsection (3)(b)(i); and

(B) the premium discounts for the employees of an employer group comply with Subsection (3)(b)(ii); or

(c) receiving premiums under an installment payment plan.

(4) Items not prohibited by Subsection (1) include a producer, consultant, or other licensee, or an officer or employee of a licensee, either directly or through a third party:

(a) engaging in a usual kind of social courtesy if receipt of the social courtesy is not conditioned on a quote or the purchase of a particular insurance product;

(b) extending credit on a premium to the insured:

(i) without interest, for no more than 90 days from the effective date of the insurance contract;

(ii) for interest that is not less than the legal rate under Section 15-1-1, on the unpaid balance after the time period described in Subsection (4)(b)(i); and

(iii) except that an installment or payroll deduction payment of premiums on an insurance contract issued under an insurer's mass marketing program is not considered an extension of credit for purposes of this Subsection (4)(b);

(c) preparing or conducting a survey that:

(i) is directly related to an accident and health insurance policy purchased from the licensee; or

(ii) is used by the licensee to assess the benefit needs and preferences of insureds, employers, or employees directly related to an insurance product sold by the licensee;

(d) providing limited human resource services that are directly related to an insurance product sold by the licensee, including:

(i) answering questions directly related to:

(A) an employee benefit offering or administration, if the insurance product purchased from the licensee is accident and health insurance or health insurance; and

(B) employment practices liability, if the insurance product offered by or purchased from the licensee is property or casualty insurance; and

(ii) providing limited human resource compliance training and education directly pertaining to an insurance product purchased from the licensee;

(e) providing the following types of information or guidance:

(i) providing guidance directly related to compliance with federal and state laws for an insurance product purchased from the licensee;

(ii) providing a workshop or seminar addressing an insurance issue that is directly related to an insurance product purchased from the licensee; or

(iii) providing information regarding:

(A) employee benefit issues;

(B) directly related insurance regulatory and legislative updates; or

(C) similar education about an insurance product sold by the licensee and how the insurance product interacts with tax law;

(f) preparing or providing a form that is directly related to an insurance product purchased from, or offered by, the licensee;

(g) preparing or providing documents directly related to a premium only cafeteria plan within the meaning of Section 125, Internal Revenue Code, or a flexible spending account, but not providing ongoing administration of a flexible spending account;

(h) providing enrollment and billing assistance, including:

(i) providing benefit statements or new hire insurance benefits packages; and

(ii) providing technology services such as an electronic enrollment platform or application system;

(i) communicating coverages in writing and in consultation with the insured and employees;

(j) providing employee communication materials and notifications directly related to an insurance product purchased from a licensee;

(k) providing claims management and resolution to the extent permitted under the licensee's license;

(l) providing underwriting or actuarial analysis or services;

(m) negotiating with an insurer regarding the placement and pricing of an insurance product;

(n) recommending placement and coverage options;

(o) providing a health fair or providing assistance or advice on establishing or operating a wellness program, but not providing any payment for or direct operation of the wellness program;

(p) providing COBRA and Utah mini-COBRA administration, consultations, and other services directly related to an insurance product purchased from the licensee;

(q) assisting with a summary plan description, including providing a summary plan description wraparound;

(r) providing information necessary for the preparation of documents directly related to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq., as amended;

(s) providing information or services directly related to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended, such as services directly related to health care access, portability, and renewability when offered in connection with accident and health insurance sold by a licensee;

(t) sending proof of coverage to a third party with a legitimate interest in coverage;

(u) providing information in a form approved by the commissioner and directly related to determining whether an insurance product sold by the licensee meets the requirements of a third party contract that requires or references insurance coverage;

(v) facilitating risk management services directly related to property and casualty insurance products sold or offered for sale by the licensee, including:

(i) risk management;

(ii) claims and loss control services;

(iii) risk assessment consulting, including analysis of:

(A) employer's job descriptions; or

(B) employer's safety procedures or manuals; and

(iv) providing information and training on best practices;

(w) otherwise providing services that are legitimately part of servicing an insurance product purchased from a licensee; and

(x) providing other directly related services approved by the department.

(5) An inducement prohibited under Subsection (1) includes a producer, consultant, or other licensee, or an officer or employee of a licensee:

(a) (i) providing a [~~premium or commission~~] rebate;

(ii) paying the salary of an employee of a person who purchases an insurance product from the licensee; or

(iii) if the licensee is an insurer, or a third party administrator who contracts with an insurer, paying the salary for an onsite staff member to perform an act prohibited under Subsection (5)(b)(xii); or

(b) engaging in one or more of the following unless a fee is paid in accordance with Subsection (8):

(i) performing background checks of prospective employees;

(ii) providing legal services by a person licensed to practice law;

(iii) performing drug testing that is directly related to an insurance product purchased from the licensee;

(iv) preparing employer or employee handbooks, except that a licensee may:

(A) provide information for a medical benefit section of an employee handbook;

(B) provide information for the section of an employee handbook directly related to an employment practices liability insurance product purchased from the licensee; or

(C) prepare or print an employee benefit enrollment guide;

(v) providing job descriptions, postings, and applications for a person;

(vi) providing payroll services;

(vii) providing performance reviews or performance review training;

(viii) providing union advice;

(ix) providing accounting services;

(x) providing data analysis information technology programs, except as provided in Subsection (4)(h)(ii);

(xi) providing administration of health reimbursement accounts or health savings accounts; or

(xii) if the licensee is an insurer, or a third party administrator who contracts with an insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of the following prohibited benefits:

(A) performing background checks of prospective employees;

(B) providing legal services by a person licensed to practice law;

(C) performing drug testing that is directly related to an insurance product purchased from the insurer;

(D) preparing employer or employee handbooks;

(E) providing job descriptions postings, and applications;

(F) providing payroll services;

(G) providing performance reviews or performance review training;

(H) providing union advice;

(I) providing accounting services;

(J) providing discrimination testing; or

(K) providing data analysis information technology programs.

(6) A producer, consultant, or other licensee or an officer or employee of a licensee shall itemize and bill separately from any other insurance product or service offered or provided under Subsection (5)(b).

(7) (a) A de minimis gift or meal not to exceed $25 for each individual receiving the gift or meal is presumed to be a social courtesy not conditioned on a quote or purchase of a particular insurance product for purposes of Subsection (4)(a).

(b) Notwithstanding Subsection (4)(a), a de minimis gift or meal not to exceed $10 may be conditioned on receipt of a quote of a particular insurance product [~~if the de minimis gift or meal is provided by the insurer and not by a producer or consultant~~].

(8) If as provided under Subsection (5)(b) a producer, consultant, or other licensee is paid a fee to provide an item listed in Subsection (5)(b), the licensee shall comply with Subsection 31A-23a-501(2) in charging the fee, except that the fee paid for the item shall equal or exceed the fair market value of the item.

Section 28. Section **31A-23a-501** is amended to read:

31A-23a-501. Licensee compensation.

(1) As used in this section:

(a) "Commission compensation" includes funds paid to or credited for the benefit of a licensee from:

(i) commission amounts deducted from insurance premiums on insurance sold by or placed through the licensee; [~~or~~]

(ii) commission amounts received from an insurer or another licensee as a result of the sale or placement of insurance[~~.~~]; or

(iii) overrides, bonuses, contingent bonuses, or contingent commissions received from an insurer or another licensee as a result of the sale or placement of insurance.

(b) (i) "Compensation from an insurer or third party administrator" means commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration:

(A) whether or not payable pursuant to a written agreement; and

(B) received from:

(I) an insurer; or

(II) a third party to the transaction for the sale or placement of insurance.

(ii) "Compensation from an insurer or third party administrator" does not mean compensation from a customer that is:

(A) a fee or pass-through costs as provided in Subsection (1)(e); or

(B) a fee or amount collected by or paid to the producer that does not exceed an amount established by the commissioner by administrative rule.

(c) (i) "Customer" means:

(A) the person signing the application or submission for insurance; or

(B) the authorized representative of the insured actually negotiating the placement of insurance with the producer.

(ii) "Customer" does not mean a person who is a participant or beneficiary of:

(A) an employee benefit plan; or

(B) a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the producer or affiliate.

(d) (i) "Noncommission compensation" includes all funds paid to or credited for the benefit of a licensee other than commission compensation.

(ii) "Noncommission compensation" does not include charges for pass-through costs incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

(e) "Pass-through costs" include:

(i) costs for copying documents to be submitted to the insurer; and

(ii) bank costs for processing cash or credit card payments.

(2) A licensee may receive from an insured or from a person purchasing an insurance policy, noncommission compensation if the noncommission compensation is stated on a

separate, written disclosure.

(a) The disclosure required by this Subsection (2) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(b) Noncommission compensation shall be:

(i) limited to actual or reasonable expenses incurred for services; and

(ii) uniformly applied to all insureds or prospective insureds in a class or classes of business or for a specific service or services.

(c) A copy of the signed disclosure required by this Subsection (2) shall be maintained by any licensee who collects or receives the noncommission compensation or any portion of the noncommission compensation.

(d) All accounting records relating to noncommission compensation shall be maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

(3) (a) A licensee may receive noncommission compensation when acting as a producer for the insured in connection with the actual sale or placement of insurance if:

(i) the producer and the insured have agreed on the producer's noncommission compensation; and

(ii) the producer has disclosed to the insured the existence and source of any other compensation that accrues to the producer as a result of the transaction.

(b) The disclosure required by this Subsection (3) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation and the existence and source of any other compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(c) The following additional noncommission compensation is authorized:

(i) compensation received by a producer of a compensated corporate surety who under procedures approved by a rule or order of the commissioner is paid by surety bond principal debtors for extra services;

(ii) compensation received by an insurance producer who is also licensed as a public adjuster under Section 31A-26-203, for services performed for an insured in connection with a claim adjustment, so long as the producer does not receive or is not promised compensation for aiding in the claim adjustment prior to the occurrence of the claim;

(iii) compensation received by a consultant as a consulting fee, provided the consultant complies with the requirements of Section 31A-23a-401; or

(iv) other compensation arrangements approved by the commissioner after a finding that they do not violate Section 31A-23a-401 and are not harmful to the public.

(d) Subject to Section 31A-23a-402.5, a producer for the insured may receive compensation from an insured through an insurer, for the negotiation and sale of a health benefit plan, if there is a separate written agreement between the insured and the licensee for the compensation. An insurer who passes through the compensation from the insured to the licensee under this Subsection (3)(d) is not providing direct or indirect compensation or commission compensation to the licensee.

(4) (a) For purposes of this Subsection (4), "producer" includes:

(i) a producer;

(ii) an affiliate of a producer; or

(iii) a consultant.

(b) A producer may not accept or receive any compensation from an insurer or third party administrator for the initial placement of a health benefit plan, other than a hospital confinement indemnity policy, unless prior to the customer's initial purchase of the health benefit plan the producer discloses in writing to the customer that the producer will receive compensation from the insurer or third party administrator for the placement of insurance, including the amount or type of compensation known to the producer at the time of the disclosure.

(c) A producer shall:

(i) obtain the customer's signed acknowledgment that the disclosure under Subsection (4)(b) was made to the customer; or

(ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to the customer; and

(B) keep the signed statement on file in the producer's office while the health benefit plan placed with the customer is in force.

(d) (i) A licensee who collects or receives any part of the compensation from an insurer or third party administrator in a manner that facilitates an audit shall, while the health benefit plan placed with the customer is in force, maintain a copy of:

(A) the signed acknowledgment described in Subsection (4)(c)(i); or

(B) the signed statement described in Subsection (4)(c)(ii).

(ii) The standard application developed in accordance with Section 31A-22-635 shall include a place for a producer to provide the disclosure required by this Subsection (4), and if completed, shall satisfy the requirement of Subsection (4)(d)(i).

(e) Subsection (4)(c) does not apply to:

(i) a person licensed as a producer who acts only as an intermediary between an insurer and the customer's producer, including a managing general agent; or

(ii) the placement of insurance in a secondary or residual market.

(5) This section does not alter the right of any licensee to recover from an insured the amount of any premium due for insurance effected by or through that licensee or to charge a reasonable rate of interest upon past-due accounts.

(6) This section does not apply to bail bond producers or bail enforcement agents as defined in Section 31A-35-102.

(7) A licensee may not receive noncommission compensation from an insured or enrollee for providing a service or engaging in an act that is required to be provided or

performed in order to receive commission compensation, except for the surplus lines transactions that do not receive commissions.

Section 29. Section **31A-23b-102** is amended to read:

31A-23b-102. Definitions.

As used in this chapter:

(1) "Compensation" is as defined in:

(a) Subsections 31A-23a-501(1)(a), (b), and (d); and

(b) PPACA.

(2) "Enroll" and "enrollment" mean to:

(a) (i) obtain personally identifiable information about an individual; and

(ii) inform an individual about accident and health insurance plans or public programs offered on an exchange;

(b) solicit insurance; or

(c) submit to the exchange:

(i) personally identifiable information about an individual; and

(ii) an individual's selection of a particular accident and health insurance plan or public program offered on the exchange.

(3) (a) "Exchange" means an online marketplace[~~: (i) for an individual to purchase a qualified health plan; and (ii)~~] that is certified by the United States Department of Health and Human Services as either a state-based small employer exchange or a federally facilitated individual exchange under PPACA.

(b) [~~(i)~~] "Exchange" does not include[~~: (A)~~] an online marketplace for the purchase of health insurance if the online marketplace is not a certified exchange [~~under PPACA; or~~] in accordance with Subsection (3)(a).

[~~(B) except as provided in Subsection (3)(b)(ii), an online marketplace for small employers that is certified as a PPACA compliant SHOP exchange.~~]

[~~(ii) For purposes of this chapter, exchange does include a small employer SHOP exchange described under Subsection (3)(b)(i)(B) if:~~]

[~~(A) federal regulations under PPACA require a small employer exchange to allow navigators to assist small employers and their employees with selection of qualified health plans on a small employer exchange; and~~]

[~~(B) the state has not entered into an agreement with the United States Department of Health and Human Services that permits the state to limit the scope of practice of navigators to only the individual PPACA exchange.~~]

(4) "Navigator":

(a) means a person who facilitates enrollment in an exchange by offering to assist, or who advertises any services to assist, with:

(i) the selection of and enrollment in a qualified health plan or a public program offered on an exchange; or

(ii) applying for premium subsidies through an exchange; and

(b) includes a person who is an in-person assister or [~~an~~] a certified application [~~assister~~] counselor as described in[~~: (i)~~] federal regulations or guidance issued under PPACA[~~; and~~].

[~~(ii) the state exchange blueprint published by the Center for Consumer Information and Insurance Oversight within the Centers for Medicare and Medicaid Services in the United States Department of Health and Human Services.~~]

(5) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

(6) "Public programs" means the state Medicaid program in Title 26, Chapter 18, Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

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

[~~(7)~~] (8) "Solicit" is as defined in Section 31A-23a-102.

Section 30. Section **31A-23b-202** is amended to read:

31A-23b-202. Qualifications for a license.

(1) (a) The commissioner shall issue or renew a license to a person to act as a navigator if the person:

(i) satisfies the:

(A) application requirements under Section 31A-23b-203;

(B) character requirements under Section 31A-23b-204;

(C) examination and training requirements under Section 31A-23b-205; and

(D) continuing education requirements under Section 31A-23b-206;

(ii) certifies that, to the extent applicable, the applicant:

(A) is in compliance with the surety bond requirements of Section 31A-23b-207; and

(B) will maintain compliance with Section 31A-23b-207 during the period for which the license is issued or renewed; and

(iii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23b-401.

(b) A license issued under this chapter is valid for [~~two years~~] one year.

(2) (a) A person shall report to the commissioner:

(i) an administrative action taken against the person, including a denial of a new or renewal license application:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) a criminal prosecution taken against the person in any jurisdiction.

(b) The report required by Subsection (2)(a) shall be filed:

(i) at the time the person files the application for an individual or agency license; and

(ii) for an action or prosecution that occurs on or after the day on which the person files the application:

(A) for an administrative action, within 30 days of the final disposition of the administrative action; or

(B) for a criminal prosecution, within 30 days of the initial appearance before a court.

(c) The report required by Subsection (2)(a) shall include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(a).

(3) (a) The department may:

(i) require a person applying for a license to submit to a criminal background check as a condition of receiving a license; or

(ii) accept a background check conducted by another organization.

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(d) Information obtained by the department from the review of criminal history records received under this Subsection (3) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-23b-204 for issuance or renewal of a license;

(ii) determining if a person failed to maintain the character requirements under Section 31A-23b-204; and

(iii) preventing a person who violates the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of a navigator or in-person assistor in the state.

(e) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of

Public Safety in providing the department criminal background information under Subsection (3)(c)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(c)(ii); and

(iii) charge the person applying for a license a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).

(4) The commissioner may deny an application for a license under this chapter if the person applying for the license:

(a) fails to satisfy the requirements of this section; or

(b) commits an act that is grounds for denial, suspension, or revocation as set forth in Section 31A-23b-401.

Section 31. Section **31A-23b-205** is amended to read:

31A-23b-205. Examination and training requirements.

(1) The commissioner may require [~~applicants~~] an applicant for a license to pass an examination and complete a training program as a requirement for a license.

(2) The examination described in Subsection (1) shall reasonably relate to:

(a) the duties and functions of a navigator;

(b) requirements for navigators as established by federal regulation under PPACA; and

(c) other requirements that may be established by the commissioner by administrative rule.

(3) The examination may be administered by the commissioner or as otherwise specified by administrative rule.

(4) The training required by Subsection (1) shall be approved by the commissioner and shall include:

(a) accident and health insurance plans;

(b) qualifications for and enrollment in public programs;

(c) qualifications for and enrollment in premium subsidies;

(d) cultural and linguistic competence;

(e) conflict of interest standards;

(f) exchange functions; and

(g) other requirements that may be adopted by the commissioner by administrative rule.

(5) The training required by Subsection (1) shall consist of:

(a) at least 21 credit hours of training before obtaining a license;

(b) at least 1 of the 21 credit hours of training described in Subsection (5)(a) on defined contribution arrangement and the small employer Health Insurance Exchange created in accordance with Title 63M, Chapter 1, Part 25, Health System Reform Act; and

(c) the navigator training and certification program developed by the Centers for Medicare and Medicaid Services.

[~~(5)~~] (6) This section applies only to [~~applicants who are natural persons~~] an applicant who is a natural person.

Section 32. Section **31A-23b-206** is amended to read:

31A-23b-206. Continuing education requirements.

(1) The commissioner shall, by rule, prescribe continuing education requirements for a navigator.

(2) (a) The commissioner may not require a degree from an institution of higher education as part of continuing education.

(b) The commissioner may state a continuing education requirement in terms of hours of instruction received in:

(i) accident and health insurance;

(ii) qualification for and enrollment in public programs;

(iii) qualification for and enrollment in premium subsidies;

(iv) cultural competency;

(v) conflict of interest standards; and

(vi) other exchange functions.

(3) (a) Continuing education requirements shall require:

(i) that a licensee complete [~~24~~] 12 credit hours of continuing education for every [~~two-year~~] one-year licensing period;

(ii) that [~~3~~] at least 2 of the [~~24~~] 12 credit hours described in Subsection (3)(a)(i) be ethics courses; [~~and~~]

[~~(iii) that the licensee complete at least half of the required hours through classroom hours of insurance and exchange related instruction.~~]

(iii) that at least 1 of the 12 credit hours described in Subsection (3)(a)(i) be a defined contribution course that includes training on use of the Health Insurance Exchange; and

(iv) that a licensee complete the annual navigator training and certification program developed by the Centers for Medicare and Medicaid Services.

(b) An hour of continuing education in accordance with Subsection (3)(a)(i) may be obtained through:

(i) classroom attendance;

(ii) home study;

(iii) watching a video recording; or

[~~(iv) experience credit; or~~]

[~~(v)~~] (iv) another method approved by rule.

(c) A licensee may obtain continuing education hours at any time during the [~~two-year~~] one-year license period.

(d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall[~~,~~] by rule[~~: (i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(b); and (ii)~~] authorize one or more continuing education providers, including a state or national professional producer or consultant associations, to:

[~~(A)~~] (i) offer a qualified program on a geographically accessible basis; and

[~~(B)~~] (ii) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner.

(4) The commissioner shall approve a continuing education provider or a continuing education course that satisfies the requirements of this section.

(5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule establish the procedures for continuing education provider registration and course approval.

(6) This section applies only to a navigator who is a natural person.

(7) A navigator shall keep documentation of completing the continuing education requirements of this section for two years after the end of the [~~two-year~~] one-year licensing period to which the continuing education applies.

Section 33. Section **31A-23b-301** is amended to read:

31A-23b-301. Unfair practices -- Compensation -- Limit of scope of practice.

(1) As used in this section, "false or misleading information" includes, with intent to deceive a person examining it:

(a) filing a report;

(b) making a false entry in a record; or

(c) willfully refraining from making a proper entry in a record.

(2) (a) Communication that contains false or misleading information relating to enrollment in an insurance plan or a public program, including information that is false or misleading because it is incomplete, may not be made by:

(i) a person who is or should be licensed under this title;

(ii) an employee of a person described in Subsection (2)(a)(i);

(iii) a person whose primary interest is as a competitor of a person licensed under this title; and

(iv) a person on behalf of [~~any of the persons~~] a person listed in this Subsection (2)(a).

(b) A licensee under this chapter may not:

(i) use [~~any~~] a business name, slogan, emblem, or related device that is misleading or likely to cause the exchange, insurer, or other licensee to be mistaken for another governmental agency, a PPACA exchange, insurer, or other licensee already in business; or

(ii) use [~~any~~] an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that a state or federal government agency, public program, or insurer:

(A) is responsible for the insurance or public program enrollment assistance activities of the person;

(B) stands behind the credit of the person; or

(C) is a source of payment of [~~any~~] an insurance obligation of or sold by the person.

(c) A person who is not an insurer may not assume or use [~~any~~] a name that deceptively implies or suggests that person is an insurer.

(3) A person may not engage in an unfair method of competition or any other unfair or deceptive act or practice in the business of insurance, as defined by the commissioner by rule, after a finding that the method of competition, the act, or the practice:

(a) is misleading;

(b) is deceptive;

(c) is unfairly discriminatory;

(d) provides an unfair inducement; or

(e) unreasonably restrains competition.

(4) A navigator licensed under this chapter is subject to the unfair marketing practices and inducement provisions of [~~Section~~] Sections 31A-23a-402 and 31A-23a-402.5.

(5) A navigator licensed under this chapter or who should be licensed under this chapter:

(a) may not receive direct or indirect compensation from an accident or health insurer or from an individual who receives services from a navigator in accordance with:

(i) federal conflict of interest regulations established pursuant to PPACA; and

(ii) administrative rule adopted by the department;

(b) may be compensated by the exchange for performing the duties of a navigator;

(c) (i) may perform, offer to perform, or advertise a service as a navigator only for a person selecting a qualified health plan or public program offered on an exchange; and

(ii) may not perform, offer to perform, or advertise [~~any~~] services as a navigator for individuals or small employer groups selecting accident and health insurance plans, qualified health plans, public programs, business, or services that are not offered on an exchange; and

(d) may not recommend a particular accident and health insurance plan or qualified health plan.

Section 34. Section **31A-23b-402** is amended to read:

31A-23b-402. Probation -- Grounds for revocation.

(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:

(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under this section; or

(b) at the issuance of a new license:

(i) with an admitted violation under 18 U.S.C. [~~Secs.~~] Sec. 1033 [~~and 1034~~]; or

(ii) with a response to background information questions on a new license application indicating that:

(A) the person has been convicted of a crime that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is a ground for probation;

(B) the person is currently charged with a crime that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is a ground for probation regardless of whether adjudication is withheld;

(C) the person has been involved in an administrative proceeding regarding any professional or occupational license; or

(D) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.

(2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Secs.~~] Sec.

1033 [~~and 1034~~].

(3) The probation order shall state the conditions for revocation or retention of the license, which shall be reasonable.

(4) Any violation of the probation is a ground for revocation pursuant to any proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Section 35. Section **31A-25-208** is amended to read:

31A-25-208. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal and reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (4);

(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-25-210; 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) If the commissioner makes a finding under Subsection (4)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke a license;

(ii) suspend a license for a specified period of 12 months or less;

(iii) limit a license in whole or in part; or

(iv) deny a license application.

(b) The commissioner may take an action described in Subsection (4)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license under Section 31A-25-202, 31A-25-203, or 31A-25-204;

(ii) has violated:

(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 third party administrator 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 third party administrator'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) has violated an insurance law, valid rule, or valid order of another state's insurance department;

(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

(xii) has improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

(xiii) has intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract; or

(B) application for insurance;

(xiv) has been convicted of a felony;

(xv) has admitted or been found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere has:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(xviii) has forged another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;

(xx) has knowingly accepted insurance business from an individual who is not licensed;

(xxi) has failed to comply with an administrative or court order imposing a child support obligation;

(xxii) has failed to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxiii) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 [~~and 1034~~] <u>and therefore under 18 U.S.C. Sec. 1033 is prohibited from engaging in the business of insurance</u>; or

(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the agency 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 participated 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 (4)(d)(ii).

(5) 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.

(6) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in any other state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by any other state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against the person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(7) (a) An order revoking a license under Subsection (4) 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 the order or agreement described in Subsection (7)(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 of the commissioner.

(8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of

a license issued under this part if so ordered by the court.

(9) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 36. Section **31A-25-209** is amended to read:

31A-25-209. Probation -- Grounds for revocation.

(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:

(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under Section 31A-25-208; or

(b) at the issuance of a new license:

(i) with an admitted violation under 18 U.S.C. [~~Sections~~] <u>Sec.</u> 1033 [~~and 1034~~]; or

(ii) with a response to a background information question on a new license application indicating that:

(A) the person has been convicted of a crime that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation;

(B) the person is currently charged with a crime that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation regardless of whether adjudication is withheld;

(C) the person has been involved in an administrative proceeding regarding any professional or occupational license; or

(D) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.

(2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Sections~~] <u>Sec.</u> 1033 [~~and 1034~~].

(3) A probation order under this section shall state the conditions for retention of the license, which shall be reasonable.

(4) A violation of the probation is grounds for revocation pursuant to any proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Section 37. Section **31A-26-102** is amended to read:

31A-26-102. Definitions.

As used in this chapter, unless expressly provided otherwise:

(1) "Company adjuster" means a person employed by an insurer whose regular duties include insurance adjusting.

(2) "Designated home state" means the state or territory of the United States or the District of Columbia:

(a) in which an insurance adjuster does not maintain the adjuster's principal:

(i) place of residence; or

(ii) place of business;

(b) if the resident state, territory, or District of Columbia of the adjuster does not license adjusters for the line of authority sought, the adjuster has qualified for the license as if the person were a resident in the state, territory, or District of Columbia described in Subsection (2)(a), including an applicable:

(i) examination requirement;

(ii) fingerprint background check requirement; and

(iii) continuing education requirement; and

(c) the adjuster has designated the state, territory, or District of Columbia as the designated home state.

(3) "Home state" means:

(a) a state or territory of the United States or the District of Columbia in which an insurance adjuster:

(i) maintains the adjuster's principal:

(A) place of residence; or

(B) place of business; and

(ii) is licensed to act as a resident adjuster; or

(b) if the resident state, territory, or the District of Columbia described in Subsection (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District of Columbia:

(i) in which the adjuster is licensed;

(ii) in which the adjuster is in good standing; and

(iii) that the adjuster has designated as the adjuster's designated home state.

[~~(2)~~] (4) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of one or more insurers.

[~~(3)~~] (5) "Insurance adjusting" or "adjusting" means directing or conducting the investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(4)~~] (6) "Organization" means a person other than a natural person, and includes a sole proprietorship by which a natural person does business under an assumed name.

[~~(5)~~] (7) "Portable electronics insurance" is as defined in Section 31A-22-1802.

[~~(6)~~] (8) "Public adjuster" means a person required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants under insurance policies.

Section 38. Section **31A-26-206** is amended to read:

31A-26-206. Continuing education requirements.

(1) Pursuant to this section, the commissioner shall by rule prescribe continuing education requirements for each class of license under Section 31A-26-204.

(2) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (2).

(b) (i) Except as otherwise provided in this section, the continuing education requirements shall require:

(A) that a licensee complete 24 credit hours of continuing education for every two-year licensing period;

(B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses; and

(C) that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

(ii) A continuing education hour completed in accordance with Subsection (2)(b)(i) may be obtained through:

(A) classroom attendance;

(B) home study;

(C) watching a video recording;

(D) experience credit; or

(E) other methods provided by rule.

(iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is required to complete 12 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses.

(c) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(d) (i) A licensee is exempt from the continuing education requirements of this section if:

(A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before May 11, 2011;

(C) the licensee requests an exemption from the department; and

(D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (2)(b); and

(ii) authorize a professional adjuster association to:

(A) offer a qualified program for a classification of license on a geographically accessible basis; and

(B) collect a reasonable fee for funding and administration of a qualified program, subject to the review and approval of the commissioner.

(f) (i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and administer a qualified program shall reasonably relate to the cost of administering the qualified program.

(ii) Nothing in this section shall prohibit a provider of a continuing education program or course from charging a fee for attendance at a course offered for continuing education credit.

(iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an association program may be less for an association member, on the basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(3) The continuing education requirements of this section apply only to a licensee who is an individual.

(4) The continuing education requirements of this section do not apply to a member of the Utah State Bar.

(5) The commissioner shall designate a course that satisfies the requirements of this section, including a course presented by an insurer.

(6) A nonresident adjuster is considered to have satisfied this state's continuing education requirements if:

(a) the nonresident adjuster satisfies the nonresident producer's home state's continuing education requirements for a licensed insurance adjuster; and

(b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's continuing education requirements for a producer as satisfying the continuing education requirements of the home state.

(7) A licensee subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education requirement applies.

Section 39. Section **31A-26-207** is amended to read:

31A-26-207. Examination requirements.

(1) The commissioner may require applicants for [~~any~~] a particular class of license under Section 31A-26-204 to pass an examination as a requirement to receiving a license. The examination shall reasonably relate to the specific license class for which it is prescribed. The examinations may be administered by the commissioner or as specified by rule.

(2) The commissioner shall waive the requirement of an examination for a nonresident applicant who:

(a) applies for an insurance adjuster license in this state;

(b) has been licensed for the same line of authority in another state; and

(c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant applies for an insurance producer license in this state; or

(ii) if the application is received within 90 days of the cancellation of the applicant's previous license:

(A) the prior state certifies that at the time of cancellation, the applicant was in good standing in that state; or

(B) the state's producer database records maintained by the National Association of Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority requested.

(3) (a) To become a resident licensee in accordance with Sections 31A-26-202 and

31A-26-203, a person licensed as an insurance producer in another state who moves to this state shall make application within 90 days of establishing legal residence in this state.

(b) A person who becomes a resident licensee under Subsection (3)(a) may not be required to meet prelicensing education or examination requirements to obtain any line of authority previously held in the prior state unless:

(i) the prior state would require a prior resident of this state to meet the prior state's prelicensing education or examination requirements to become a resident licensee; or

(ii) the commissioner imposes the requirements by rule.

(4) The requirements of this section only apply to [~~applicants who are natural persons~~] an applicant who is a natural person.

(5) The requirements of this section do not apply to [~~members~~]:

(a) a member of the Utah State Bar[~~.~~]; or

(b) an applicant for the crop insurance license class who has satisfactorily completed:

(i) a national crop adjuster program, as adopted by the commissioner by rule; or

(ii) the loss adjustment training curriculum and competency testing required by the Federal Crop Insurance Corporation Standard Reinsurance Agreement through the Risk Management Agency of the United States Department of Agriculture.

Section 40. Section **31A-26-213** is amended to read:

31A-26-213. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- 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-26-214.5; 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 it 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 license classification issued under this chapter remains in force until:

(a) the qualifications pertaining to a license classification are no longer met by the licensee; or

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5); or

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action.

(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 license classification;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a license classification;

(iii) limit in whole or in part:

(A) a license; or

(B) a license classification; or

(iv) deny a license application.

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license or license classification under Section 31A-26-202, 31A-26-203, 31A-26-204, or 31A-26-205;

(ii) has violated:

(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 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 adjuster 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 adjuster'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) has violated an insurance law, valid rule, or valid order of another state's insurance department;

(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

(xii) has improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

(xiii) has intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract; or

(B) application for insurance;

(xiv) has been convicted of a felony;

(xv) has admitted or been found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere has:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(xviii) has forged another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;

(xx) has knowingly accepted insurance business from an individual who is not licensed;

(xxi) has failed to comply with an administrative or court order imposing a child support obligation;

(xxii) has failed to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxiii) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 [~~and 1034~~] and therefore under 18 U.S.C. Sec. 1033 is prohibited from engaging in the business of insurance; or

(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participated 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 conducting an insurance business 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 any other state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by any other 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 the order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years without the express approval of 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 41. Section **31A-26-214** is amended to read:

31A-26-214. Probation -- Grounds for revocation.

(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:

(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under Section 31A-26-213; or

(b) at the issuance of a new license:

(i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or

(ii) with a response to a background information question on any new license application indicating that:

(A) the person has been convicted of a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation;

(B) the person is currently charged with a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation regardless of whether adjudication was withheld;

(C) the person has been involved in an administrative proceeding regarding any professional or occupational license; or

(D) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.

(2) The commissioner may put a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to violations under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~].

(3) A probation order under this section shall state the conditions for retention of the license, which shall be reasonable.

(4) A violation of the probation is grounds for revocation pursuant to any proceeding

authorized under Title 63G, Chapter 4, Administrative Procedures Act.

Section 42. Section **31A-26-214.5** is amended to read:

31A-26-214.5. License lapse and voluntary surrender.

(1) (a) A license issued under this chapter shall lapse if the licensee fails to:

(i) pay when due a fee under Section 31A-3-103;

(ii) complete continuing education requirements under Section 31A-26-206 before submitting the license renewal application;

(iii) submit a completed renewal application as required by Section 31A-26-202;

(iv) submit additional documentation required to complete the licensing process as related to a specific license type or license classification; or

(v) maintain an active license in [~~a resident~~] the licensee's home state if the licensee is a nonresident licensee.

(b) (i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):

(A) military service;

(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or

(C) some other extenuating circumstances, such as long-term medical disability.

(ii) A licensee described in Subsection (1)(b)(i) may request:

(A) reinstatement of the license no later than one year after the day on which the license lapses; and

(B) waiver of any of the following imposed for failure to comply with renewal procedures:

(I) an examination requirement;

(II) reinstatement fees set under Section 31A-3-103;

(III) continuing education requirements; or

(IV) other sanction imposed for failure to comply with renewal procedures.

(2) If a license issued under this chapter is voluntarily surrendered, the license may be

reinstated:

(a) during the license period in which it is voluntarily surrendered; and

(b) no later than one year after the day on which the license is voluntarily surrendered.

Section 43. Section **31A-27a-102** is amended to read:

31A-27a-102. Definitions.

As used in this chapter:

(1) "Admitted assets" is as defined by and is measured in accordance with the National Association of Insurance Commissioner's Statements of Statutory Accounting Principles, as incorporated in this state by rules made by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection 31A-4-113(1)(b)(ii).

(2) "Affected guaranty association" means a guaranty association that is or may become liable for payment of a covered claim.

(3) "Affiliate" is as defined in Section 31A-1-301.

(4) Notwithstanding Section 31A-1-301, "alien insurer" means an insurer incorporated or organized under the laws of a jurisdiction that is not a state.

(5) Notwithstanding Section 31A-1-301, "claimant" or "creditor" means a person having a claim against an insurer whether the claim is:

(a) matured or not matured;

(b) liquidated or unliquidated;

(c) secured or unsecured;

(d) absolute; or

(e) fixed or contingent.

(6) "Commissioner" is as defined in Section 31A-1-301.

(7) "Commodity contract" means:

(a) a contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of:

(i) a board of trade or contract market under the Commodity Exchange Act, 7 U.S.C.

Sec. 1 et seq.; or

(ii) a board of trade outside the United States;

(b) an agreement that is:

(i) subject to regulation under Section 19 of the Commodity Exchange Act, 7 U.S.C. Sec. 1 et seq.; and

(ii) commonly known to the commodities trade as:

(A) a margin account;

(B) a margin contract;

(C) a leverage account; or

(D) a leverage contract;

(c) an agreement or transaction that is:

(i) subject to regulation under Section 4c(b) of the Commodity Exchange Act, 7 U.S.C. Sec. 1 et seq.; and

(ii) commonly known to the commodities trade as a commodity option;

(d) a combination of the agreements or transactions referred to in this Subsection (7); or

(e) an option to enter into an agreement or transaction referred to in this Subsection (7).

(8) "Control" is as defined in Section 31A-1-301.

(9) "Delinquency proceeding" means a:

(a) proceeding instituted against an insurer for the purpose of rehabilitating or liquidating the insurer; and

(b) summary proceeding under Section 31A-27a-201.

(10) "Department" is as defined in Section 31A-1-301 unless the context requires otherwise.

(11) "Doing business," "doing insurance business," and "business of insurance" includes any of the following acts, whether effected by mail, electronic means, or otherwise:

(a) issuing or delivering a contract, certificate, or binder relating to insurance or annuities:

(i) to a person who is resident in this state; or

(ii) covering a risk located in this state;

(b) soliciting an application for the contract, certificate, or binder described in Subsection (11)(a);

(c) negotiating preliminary to the execution of the contract, certificate, or binder described in Subsection (11)(a);

(d) collecting premiums, membership fees, assessments, or other consideration for the contract, certificate, or binder described in Subsection (11)(a);

(e) transacting matters:

(i) subsequent to execution of the contract, certificate, or binder described in Subsection (11)(a); and

(ii) arising out of the contract, certificate, or binder described in Subsection (11)(a);

(f) operating as an insurer under a license or certificate of authority issued by the department; or

(g) engaging in an act identified in Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups.

(12) Notwithstanding Section 31A-1-301, "domiciliary state" means the state in which an insurer is incorporated or organized, except that "domiciliary state" means:

(a) in the case of an alien insurer, its state of entry; or

(b) in the case of a risk retention group, the state in which the risk retention group is chartered as contemplated in the Liability Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.

(13) "Estate" has the same meaning as "property of the insurer" as defined in Subsection (30).

(14) "Fair consideration" is given for property or an obligation:

(a) when in exchange for the property or obligation, as a fair equivalent for it, and in good faith:

(i) property is conveyed;

(ii) services are rendered;

(iii) an obligation is incurred; or

(iv) an antecedent debt is satisfied; or

(b) when the property or obligation is received in good faith to secure a present advance or an antecedent debt in amount not disproportionately small compared to the value of the property or obligation obtained.

(15) Notwithstanding Section 31A-1-301, "foreign insurer" means an insurer domiciled in another state.

(16) "Formal delinquency proceeding" means a rehabilitation or liquidation proceeding.

(17) "Forward contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C. Sec. 1821(e)(8)(D).

(18) (a) "General assets" include all property of the estate that is not:

(i) subject to a properly perfected secured claim;

(ii) subject to a valid and existing express trust for the security or benefit of a specified person or class of person; or

(iii) required by the insurance laws of this state or any other state to be held for the benefit of a specified person or class of person.

(b) "General assets" [~~include all~~] includes the property of the estate or its proceeds in excess of the amount necessary to discharge a claim described in Subsection (18)(a).

(19) "Good faith" means honesty in fact and intention, and in regard to Part 5, Asset Recovery, also requires the absence of:

(a) information that would lead a reasonable person in the same position to know that the insurer is financially impaired or insolvent; and

(b) knowledge regarding the imminence or pendency of a delinquency proceeding against the insurer.

(20) "Guaranty association" means:

(a) a mechanism mandated by Chapter 28, Guaranty Associations; or

(b) a similar mechanism in another state that is created for the payment of claims or continuation of policy obligations of a financially impaired or insolvent insurer.

(21) "Impaired" means that an insurer:

(a) does not have admitted assets at least equal to the sum of:

(i) all its liabilities; and

(ii) the minimum surplus required to be maintained by Section 31A-5-211 or 31A-8-209; or

(b) has a total adjusted capital that is less than its authorized control level RBC, as defined in Section 31A-17-601.

(22) "Insolvency" or "insolvent" means that an insurer:

(a) is unable to pay its obligations when they are due;

(b) does not have admitted assets at least equal to all of its liabilities; or

(c) has a total adjusted capital that is less than its mandatory control level RBC, as defined in Section 31A-17-601.

(23) Notwithstanding Section 31A-1-301, "insurer" means a person who:

(a) is doing, has done, purports to do, or is licensed to do the business of insurance;

(b) is or has been subject to the authority of, or to rehabilitation, liquidation, reorganization, supervision, or conservation by an insurance commissioner; or

(c) is included under Section 31A-27a-104.

(24) "Liabilities" is as defined by and is measured in accordance with the National Association of Insurance Commissioner's Statements of Statutory Accounting Principles, as incorporated in this state by rules made by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection 31A-4-113(1)(b)(ii).

(25) (a) Subject to Subsection (21)(b), "netting agreement" means:

(i) a contract or agreement that:

(A) documents one or more transactions between the parties to the agreement for or involving one or more qualified financial contracts; and

(B) provides for the netting, liquidation, setoff, termination, acceleration, or close out under or in connection with:

(I) one or more qualified financial contracts; or

(II) present or future payment or delivery obligations or payment or delivery entitlements under the agreement, including liquidation or close-out values relating to the obligations or entitlements, among the parties to the netting agreement;

(ii) a master agreement or bridge agreement for one or more master agreements described in Subsection (25)(a)(i); or

(iii) any of the following related to a contract or agreement described in Subsection (25)(a)(i) or (ii):

(A) a security agreement;

(B) a security arrangement;

(C) other credit enhancement or guarantee; or

(D) a reimbursement obligation.

(b) If a contract or agreement described in Subsection (25)(a)(i) or (ii) relates to an agreement or transaction that is not a qualified financial contract, the contract or agreement described in Subsection (25)(a)(i) or (ii) is considered a netting agreement only with respect to an agreement or transaction that is a qualified financial contract.

(c) "Netting agreement" includes:

(i) a term or condition incorporated by reference in the contract or agreement described in Subsection (25)(a); or

(ii) a master agreement described in Subsection (25)(a).

(d) A master agreement described in Subsection (25)(a), together with all schedules, confirmations, definitions, and addenda to that master agreement and transactions under any of the items described in this Subsection (25)(d), are treated as one netting agreement.

(26) (a) "New value" means:

(i) money;

(ii) money's worth in goods, services, or new credit; or

(iii) release by a transferee of property previously transferred to the transferee in a transaction that is neither void nor voidable by the insurer or the receiver under [~~any~~] applicable law, including proceeds of the property.

(b) "New value" does not include an obligation substituted for an existing obligation.

(27) "Party in interest" means:

(a) the commissioner;

(b) a nondomiciliary commissioner in whose state the insurer has outstanding claims liabilities;

(c) an affected guaranty association; and

(d) the following parties if the party files a request with the receivership court for inclusion as a party in interest and to be on the service list:

(i) an insurer that ceded to or assumed business from the insurer;

(ii) a policyholder;

(iii) a third party claimant;

(iv) a creditor;

(v) a 10% or greater equity security holder in the insolvent insurer; and

(vi) a person, including an indenture trustee, with a financial or regulatory interest in the delinquency proceeding.

(28) (a) Notwithstanding Section 31A-1-301, "policy" means, notwithstanding what it is called:

(i) a written contract of insurance;

(ii) a written agreement for or affecting insurance; or

(iii) a certificate of a written contract or agreement described in this Subsection (28)(a).

(b) "Policy" includes all clauses, riders, endorsements, and papers that are a part of a policy.

(c) "Policy" does not include a contract of reinsurance.

(29) "Preference" means a transfer of property of an insurer to or for the benefit of a creditor:

(a) for or on account of an antecedent debt, made or allowed by the insurer within one year before the day on which a successful petition for rehabilitation or liquidation is filed under this chapter;

(b) the effect of which transfer may enable the creditor to obtain a greater percentage of the creditor's debt than another creditor of the same class would receive; and

(c) if a liquidation order is entered while the insurer is already subject to a rehabilitation order and the transfer otherwise qualifies, that is made or allowed within the shorter of:

(i) one year before the day on which a successful petition for rehabilitation is filed; or

(ii) two years before the day on which a successful petition for liquidation is filed.

(30) "Property of the insurer" or "property of the estate" includes:

(a) a right, title, or interest of the insurer in property:

(i) whether:

(A) legal or equitable;

(B) tangible or intangible; or

(C) choate or inchoate; and

(ii) including choses in action, contract rights, and any other interest recognized under the laws of this state;

(b) entitlements that exist before the entry of an order of rehabilitation or liquidation;

(c) entitlements that may arise by operation of this chapter or other provisions of law allowing the receiver to avoid prior transfers or assert other rights; and

(d) (i) records or data that is otherwise the property of the insurer; and

(ii) records or data similar to those described in Subsection (30)(d)(i) that are within the possession, custody, or control of a managing general agent, a third party administrator, a management company, a data processing company, an accountant, an attorney, an affiliate, or other person.

(31) Subject to Subsection 31A-27a-611(10), "qualified financial contract" means any of the following:

(a) a commodity contract;

(b) a forward contract;

(c) a repurchase agreement;

(d) a securities contract;

(e) a swap agreement; or

(f) [~~any~~] a similar agreement that the commissioner determines by rule or order to be a qualified financial contract for purposes of this chapter.

(32) As the context requires, "receiver" means the commissioner or the commissioner's designee, including a rehabilitator, liquidator, or ancillary receiver.

(33) As the context requires, "receivership" means a rehabilitation, liquidation, or ancillary receivership.

(34) Unless the context requires otherwise, "receivership court" refers to the court in which a delinquency proceeding is pending.

(35) "Reciprocal state" means [~~any~~] a state other than this state that:

(a) enforces a law substantially similar to this chapter;

(b) requires the commissioner to be the receiver of a delinquent insurer; and

(c) has laws for the avoidance of fraudulent conveyances and preferential transfers by the receiver of a delinquent insurer.

(36) "Record," when used as a noun, means [~~any~~] information or data, in whatever form maintained, including:

(a) a book;

(b) a document;

(c) a paper;

(d) a file;

(e) an application file;

(f) a policyholder list;

(g) policy information;

(h) a claim or claim file;

(i) an account;

(j) a voucher;

(k) a litigation file;

(l) a premium record;

(m) a rate book;

(n) an underwriting manual;

(o) a personnel record;

(p) a financial record; or

(q) other material.

(37) "Reinsurance" means a transaction or contract under which an assuming insurer agrees to indemnify a ceding insurer against all, or a part, of [~~any~~] a loss that the ceding insurer may sustain under the one or more policies that the ceding insurer issues or will issue.

(38) "Repurchase agreement" is as defined in the Federal Deposit Insurance Act, 12 U.S.C. Sec. 1821(e)(8)(D).

(39) (a) "Secured claim" means, subject to Subsection (39)(b):

(i) a claim secured by an asset that is not a general asset; or

(ii) the right to set off as provided in Section 31A-27a-510.

(b) "Secured claim" does not include:

(i) a special deposit claim;

(ii) a claim based on mere possession; or

(iii) a claim arising from a constructive or resulting trust.

(40) "Securities contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C. Sec. 1821(e)(8)(D).

(41) "Special deposit" means a deposit established pursuant to statute for the security or benefit of a limited class or classes of persons.

(42) (a) Subject to Subsection (42)(b), "special deposit claim" means a claim secured by a special deposit.

(b) "Special deposit claim" does not include a claim against the general assets of the insurer.

(43) "State" means a state, district, or territory of the United States.

(44) "Subsidiary" is as defined in Section 31A-1-301.

(45) "Swap agreement" is as defined in the Federal Deposit Insurance Act, 12 U.S.C. Sec. 1821(e)(8)(D).

(46) (a) "Transfer" includes the sale and every other and different mode of disposing of or parting with property or with an interest in property, whether:

(i) directly or indirectly;

(ii) absolutely or conditionally;

(iii) voluntarily or involuntarily; or

(iv) by or without judicial proceedings.

(b) An interest in property includes:

(i) a set off;

(ii) having possession of the property; or

(iii) fixing a lien on the property or on an interest in the property.

(c) The retention of a security title in property delivered to an insurer and foreclosure of the insurer's equity of redemption is considered a transfer suffered by the insurer.

(47) Notwithstanding Section 31A-1-301, "unauthorized insurer" means an insurer transacting the business of insurance in this state that has not received a certificate of authority from this state, or some other type of authority that allows for the transaction of the business of insurance in this state.

Section 44. Section **31A-27a-107** is amended to read:

31A-27a-107. Notice and hearing on matters submitted by the receiver for receivership court approval.

(1) (a) Upon written request to the receiver, a person shall be placed on the service list to receive notice of matters filed by the receiver. <u>The person shall include in a written request under this Subsection (1)(a) the person's address, facsimile number, or electronic mail address.</u>

(b) It is the responsibility of the person requesting notice to:

(i) inform the receiver in writing of any changes in the person's address<u>, facsimile</u>

number, or electronic mail address; or

(ii) request that the person's name be deleted from the service list.

(c) (i) The receiver may serve on a person on the service list a request to confirm continuation on the service list by returning a form.

(ii) The request to confirm continuation may be served periodically but not more frequently than every 12 months.

(iii) A person who fails to return the form described in this Subsection (1)(c) may be removed from the service list.

(d) Inclusion on the service list does not confer standing in the delinquency proceeding to raise, appear, or be heard on any issue.

(e) The receiver shall:

(i) file a copy of the service list with the receivership court; and

(ii) periodically provide to the receivership court notice of changes to the service list.

(f) Notice may be provided by first-class mail postage paid, electronic mail, or facsimile transmission, at the receiver's discretion.

(2) Except as otherwise provided by this chapter, notice and hearing of any matter submitted by the receiver to the receivership court for approval under this chapter shall be conducted in accordance with this Subsection (2).

(a) The receiver:

(i) shall file a motion:

(A) explaining the proposed action; and

(B) the basis for the proposed action; and

(ii) may include any evidence in support of the motion.

(b) If a document, material, or other information supporting the motion is confidential, the document, material, or other information may be submitted to the receivership court under seal for in camera inspection.

(c) (i) The receiver shall provide notice and a copy of the motion to:

(A) all persons on the service list; and

(B) any other person as may be required by the receivership court.

(ii) Notice may be provided by first-class mail postage paid, electronic mail, or facsimile transmission, at the receiver's discretion.

(iii) For purposes of this section, notice is considered to be given on the day on which it is deposited with the United States Postmaster or transmitted, as applicable, to the last-known address as shown on the service list.

(d) (i) A party in interest objecting to the motion shall:

(A) file an objection specifying the grounds for the objection within:

(I) 10 days of the day on which the notice of the filing of the motion is sent; or

(II) such other time as the receivership court may specify; and

(B) serve copies on:

(I) the receiver; and

(II) any other person served with the motion within the time period described in this Subsection (2)(d)(i).

(ii) In accordance with the Utah Rules of Civil Procedure, days may be added to the time for filing an objection if the notice of the motion is sent only by way of United States mail.

(iii) An objecting party has the burden of showing why the receivership court should not authorize the proposed action.

(e) (i) If no objection to the motion is timely filed:

(A) the receivership court may:

(I) enter an order approving the motion without a hearing; or

(II) hold a hearing to determine if the receiver's motion should be approved; and

(B) the receiver may request that the receivership court enter an order or hold a hearing on an expedited basis.

(ii) (A) If an objection is timely filed, the receivership court may hold a hearing.

(B) If the receivership court approves the motion and, upon a motion by the receiver, determines that the objection is frivolous or filed merely for delay or for other improper purpose, the receivership court may order the objecting party to pay the receiver's reasonable costs and fees of defending against the objection.

Section 45. Section **31A-27a-201** is amended to read:

31A-27a-201. Receivership court's seizure order.

(1) The commissioner may file in the Third District Court for Salt Lake County a petition:

(a) with respect to:

(i) an insurer domiciled in this state;

(ii) an unauthorized insurer; or

(iii) pursuant to Section 31A-27a-901, a foreign insurer;

(b) alleging that:

(i) there exists grounds that would justify a court order for a formal delinquency proceeding against the insurer under this chapter; and

(ii) the interests of policyholders, creditors, or the public will be endangered by delay; and

(c) setting forth the contents of a seizure order considered necessary by the commissioner.

(2) (a) Upon a filing under Subsection (1), the receivership court may issue the requested seizure order:

(i) immediately, ex parte, and without notice or hearing;

(ii) that directs the commissioner to take possession and control of:

(A) all or a part of the property, accounts, and records of an insurer; and

(B) the premises occupied by the insurer for transaction of the insurer's business; and

(iii) that until further order of the receivership court, enjoins the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner.

(b) [~~Any~~] A person having possession or control of and refusing to deliver any of the records or assets of a person against whom a seizure order is issued under this Subsection (2) is guilty of a class B misdemeanor.

(3) (a) A petition that requests injunctive relief:

(i) shall be verified by the commissioner or the commissioner's designee; and

(ii) is not required to plead or prove irreparable harm or inadequate remedy at law.

(b) The commissioner shall provide only the notice that the receivership court may require.

(4) (a) The receivership court shall specify in the seizure order the duration of the seizure, which shall be the time the receivership court considers necessary for the commissioner to ascertain the condition of the insurer.

(b) The receivership court may from time to time:

(i) hold a hearing that the receivership court considers desirable:

(A) (I) on motion of the commissioner;

(II) on motion of the insurer; or

(III) on its own motion; and

(B) after the notice the receivership court considers appropriate; and

(ii) extend, shorten, or modify the terms of the seizure order.

(c) The receivership court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this chapter after having had a reasonable opportunity to commence a formal proceeding under this chapter.

(d) An order of the receivership court pursuant to a formal proceeding under this chapter vacates the seizure order.

(5) Entry of a seizure order under this section does not constitute a breach or an anticipatory breach of [~~any~~] a contract of the insurer.

(6) (a) An insurer subject to an ex parte seizure order under this section may petition the receivership court at any time after the issuance of a seizure order for a hearing and review of the basis for the seizure order.

(b) The receivership court shall hold the hearing and review requested under this Subsection (6) not more than 15 days after the day on which the request is received or as soon thereafter as the court may allow.

(c) A hearing under this Subsection (6):

(i) may be held privately in chambers; and

(ii) shall be held privately in chambers if the insurer proceeded against requests that it be private.

(7) (a) If, at any time after the issuance of a seizure order, it appears to the receivership court that a person whose interest is or will be substantially affected by the seizure order did not appear at the hearing and has not been served, the receivership court may order that notice be given to the person.

(b) An order under this Subsection (7) that notice be given may not stay the effect of [~~any~~] a seizure order previously issued by the receivership court.

(8) Whenever the commissioner makes a seizure as provided in Subsection (2), on the demand of the commissioner, it shall be the duty of the sheriff of a county of this state, and of the police department of a municipality in the state to furnish the commissioner with necessary deputies or officers to assist the commissioner in making and enforcing the seizure order.

(9) The commissioner may appoint a receiver under this section. The insurer shall pay the costs and expenses of the receiver appointed.

Section 46. Section **31A-27a-701** is amended to read:

31A-27a-701. Priority of distribution.

(1) (a) The priority of payment of distributions on unsecured claims shall be in accordance with the order in which each class of claim is set forth in this section except as provided in Section 31A-27a-702.

(b) All claims in each class shall be paid in full or adequate funds retained for the claim's payment before a member of the next class receives payment.

(c) All claims within a class shall be paid substantially the same percentage.

(d) Except as provided in Subsections (2)(a)(i)(E), (2)(k), and (2)(m), subclasses may not be established within a class.

(e) A claim by a shareholder, policyholder, or other creditor may not be permitted to circumvent the priority classes through the use of equitable remedies.

(2) The order of distribution of claims shall be as follows:

(a) a Class 1 claim, which:

(i) is a cost or expense of administration expressly approved or ratified by the liquidator, including the following:

(A) the actual and necessary costs of preserving or recovering the property of the insurer;

(B) reasonable compensation for all services rendered on behalf of the administrative supervisor or receiver;

(C) a necessary filing fee;

(D) the fees and mileage payable to a witness;

(E) an unsecured loan obtained by the receiver, which:

(I) unless its terms otherwise provide, has priority over all other costs of administration; and

(II) absent agreement to the contrary, shares pro rata with all other claims described in this Subsection (2)(a)(i)(E); and

(F) an expense approved by the rehabilitator of the insurer, if any, incurred in the course of the rehabilitation that is unpaid at the time of the entry of the order of liquidation; and

(ii) except as expressly approved by the receiver, excludes any expense arising from a duty to indemnify a director, officer, or employee of the insurer which expense, if allowed, is a Class 7 claim;

(b) a Class 2 claim, which:

(i) is a reasonable expense of a guaranty association, including overhead, salaries, or other general administrative expenses allocable to the receivership such as:

(A) an administrative or claims handling expense;

(B) an expense in connection with arrangements for ongoing coverage; and

(C) in the case of a property and casualty guaranty association, a loss adjustment expense, including:

(I) an adjusting or other expense; and

(II) a defense or cost containment expense; and

(ii) excludes an expense incurred in the performance of duties under Section 31A-28-112 or similar duties under the statute governing a similar organization in another state;

(c) a Class 3 claim, which:

(i) is:

(A) a claim under a policy of insurance including a third party claim;

(B) a claim under an annuity contract or funding agreement;

(C) a claim under a nonassessable policy for unearned premium;

(D) a claim of an obligee and, subject to the discretion of the receiver, a completion contractor under a surety bond or surety undertaking, except for:

(I) a bail bond;

(II) a mortgage guaranty;

(III) a financial guaranty; or

(IV) other form of insurance offering protection against investment risk or warranties;

(E) a claim by a principal under a surety bond or surety undertaking for wrongful dissipation of collateral by the insurer or its agents;

(F) an indemnity payment on:

(I) a covered claim; or

[~~(II) unearned premium; or~~]

[~~(III)~~] (II) a payment for the continuation of coverage made by an entity responsible for the payment of a claim or continuation of coverage of an insolvent health maintenance organization;

(G) a claim for unearned premium;

[~~(G)~~] (H) a claim incurred during the extension of coverage provided for in Sections 31A-27a-402 and 31A-27a-403; or

[~~(H)~~] (I) all other claims incurred in fulfilling the statutory obligations of a guaranty association not included in Class 2, including:

(I) an indemnity payment on covered claims; and

(II) in the case of a life and health guaranty association, a claim:

(Aa) as a creditor of the impaired or insolvent insurer for a payment of and liabilities incurred on behalf of a covered claim or covered obligation of the insurer; and

(Bb) for the funds needed to reinsure the obligations described under this Subsection (2)(c)(i)(H)(II) with a solvent insurer; and

(ii) notwithstanding any other provision of this chapter, excludes the following which shall be paid under Class 7, except as provided in this section:

(A) an obligation of the insolvent insurer arising out of a reinsurance contract;

(B) an obligation that is incurred pursuant to an occurrence policy or reported pursuant to a claims made policy after:

(I) the expiration date of the policy;

(II) the policy is replaced by the insured;

(III) the policy is canceled at the insured's request; or

(IV) the policy is canceled as provided in this chapter;

(C) an obligation to an insurer, insurance pool, or underwriting association and the insurer's, insurance pool's, or underwriting association's claim for contribution, indemnity, or subrogation, equitable or otherwise, except for direct claims under a policy where the insurer is the named insured;

(D) an amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy, which shall be paid as a claim in Class 9;

(E) a tort claim of any kind against the insurer;

(F) a claim against the insurer for bad faith or wrongful settlement practices; and

(G) a claim of a guaranty association for assessments not paid by the insurer, which claims shall be paid as claims in Class 7; and

(iii) notwithstanding Subsection (2)(c)(ii)(B), does not exclude an unearned premium claim on a policy, other than a reinsurance agreement;

(d) a Class 4 claim, which is a claim under a policy for mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risk or warranties;

(e) a Class 5 claim, which is a claim of the federal government not included in Class 3 or 4;

(f) a Class 6 claim, which is a debt due an employee for services or benefits:

(i) to the extent that the expense:

(A) does not exceed the lesser of:

(I) $5,000; or

(II) two months' salary; and

(B) represents payment for services performed within one year before the day on which the initial order of receivership is issued; and

(ii) which priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees;

(g) a Class 7 claim, which is a claim of an unsecured creditor not included in Classes 1 through 6, including:

(i) a claim under a reinsurance contract;

(ii) a claim of a guaranty association for an assessment not paid by the insurer; and

(iii) other claims excluded from Class 3 or 4, unless otherwise assigned to Classes 8 through 13;

(h) subject to Subsection (3), a Class 8 claim, which is:

(i) a claim of a state or local government, except a claim specifically classified elsewhere in this section; or

(ii) a claim for services rendered and expenses incurred in opposing a formal delinquency proceeding;

(i) a Class 9 claim, which is a claim for penalties, punitive damages, or forfeitures, unless expressly covered under the terms of a policy of insurance;

(j) a Class 10 claim, which is, except as provided in Subsections 31A-27a-601(2) and 31A-27a-601(3), a late filed claim that would otherwise be classified in Classes 3 through 9;

(k) subject to Subsection (4), a Class 11 claim, which is:

(i) a surplus note;

(ii) a capital note;

(iii) a contribution note;

(iv) a similar obligation;

(v) a premium refund on an assessable policy; or

(vi) any other claim specifically assigned to this class;

(l) a Class 12 claim, which is a claim for interest on an allowed claim of Classes 1 through 11, according to the terms of a plan to pay interest on allowed claims proposed by the liquidator and approved by the receivership court; and

(m) subject to Subsection (4), a Class 13 claim, which is a claim of a shareholder or other owner arising out of:

(i) the shareholder's or owner's capacity as shareholder or owner or any other capacity; and

(ii) except as the claim may be qualified in Class 3, 4, 7, or 12.

(3) To prove a claim described in Class 8, the claimant shall show that:

(a) the insurer that is the subject of the delinquency proceeding incurred the fee or expense on the basis of the insurer's best knowledge, information, and belief:

(i) formed after reasonable inquiry indicating opposition is in the best interests of the insurer;

(ii) that is well grounded in fact; and

(iii) is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law; and

(b) opposition is not pursued for any improper purpose, such as to harass, to cause unnecessary delay, or to cause needless increase in the cost of the litigation.

(4) (a) A claim in Class 11 is subject to a subordination agreement related to other claims in Class 11 that exist before the entry of a liquidation order.

(b) A claim in Class 13 is subject to a subordination agreement, related to other claims in Class 13 that exist before the entry of a liquidation order.

Section 47. Section **31A-29-106** is amended to read:

31A-29-106. Powers of board.

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health care insurance business. In addition, the board shall have the specific authority to:

(a) enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:

(i) similar pools of other states for the joint performance of common administrative functions; or

(ii) persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking such legal action necessary to avoid the payment of improper claims against the pool or the coverage provided through the pool;

(c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;

(d) issue policies of insurance in accordance with the requirements of this chapter;

(e) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool;

(f) establish rules, conditions, and procedures for reinsuring risks under this chapter;

(g) cause the pool to have an annual audit of its operations by the state auditor;

(h) coordinate with the Department of Health in seeking to obtain from the Centers for Medicare and Medicaid Services, or other appropriate office or agency of government, all appropriate waivers, authority, and permission needed to coordinate the coverage available from the pool with coverage available under Medicaid, either before or after Medicaid coverage, or as a conversion option upon completion of Medicaid eligibility, without the necessity for requalification by the enrollee;

(i) provide for and employ cost containment measures and requirements including preadmission certification, concurrent inpatient review, and individual case management for the purpose of making the pool more cost-effective;

(j) offer pool coverage through contracts with health maintenance organizations, preferred provider organizations, and other managed care systems that will manage costs while maintaining quality care;

(k) establish annual limits on benefits payable under the pool to or on behalf of any enrollee;

(l) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;

(m) administer the Pool Fund;

(n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this chapter;

(o) adopt, trademark, and copyright a trade name for the pool for use in marketing and publicizing the pool and its products; and

(p) transition health care coverage for all individuals covered under the pool as part of the conversion to health insurance coverage, regardless of preexisting conditions, under PPACA.

(2) (a) The board shall prepare and submit an annual report to the Legislature which shall include:

(i) the net premiums anticipated;

(ii) actuarial projections of payments required of the pool;

(iii) the expenses of administration; and

(iv) the anticipated reserves or losses of the pool.

(b) The budget for operation of the pool is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

[~~(3) (a) The board shall on or before September 1, 2004, require the plan administrator~~

~~or an independent actuarial consultant retained by the plan administrator to redetermine the reasonable equivalent of the criteria for uninsurability required under Subsection 31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.~~]

[~~(b) The board shall redetermine the criteria established in Subsection (3)(a) at least every five years thereafter.~~]

Section 48. Section **31A-29-111** is amended to read:

31A-29-111. Eligibility -- Limitations.

(1) (a) Except as provided in Subsection (1)(b), an individual who is not HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium;

(ii) is a resident of this state; and

(iii) meets the health underwriting criteria under Subsection (5)(a).

(b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual has terminated coverage in the pool, unless:

(A) 12 months have elapsed since the termination date; or

(B) the individual demonstrates that creditable coverage has been involuntarily terminated for any reason other than nonpayment of premium;

(iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(iv) the individual is an inmate of a public institution;

(v) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. <u>Sec.</u> 300gg;

(vi) the individual's health condition does not meet the criteria established under Subsection (5);

(vii) the individual is eligible for coverage under an employer group that offers a health benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(viii) the individual is covered under any other health benefit plan;

(ix) except as provided in Subsections (3) and (6), at the time of application, the individual has not resided in Utah for at least 12 consecutive months preceding the date of application; or

(x) the individual's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.

(2) (a) Except as provided in Subsection (2)(b), an individual who is HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium; and

(ii) is a resident of this state.

(b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. Sec. 300gg;

(iii) the individual is covered under any other health benefit plan;

(iv) the individual is eligible for coverage under an employer group that offers a health benefit plan or self-insurance arrangements to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(vi) the individual is an inmate of a public institution; or

(vii) the individual's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.

(3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose health care insurance coverage from a state high risk pool with similar coverage is terminated because of nonresidency in another state is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

(b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the termination date of the previous high risk pool coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous high risk pool coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived:

(i) to the extent to which the waiting period was satisfied under a similar plan from another state; and

(ii) if the other state's benefit limitation was not reached.

(4) (a) If an eligible individual applies for pool coverage within 30 days of being denied coverage by an individual carrier, the effective date for pool coverage shall be no later than the first day of the month following the date of submission of the completed insurance application to the carrier.

(b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under Subsection (3), the effective date shall be the date of termination of the previous high risk pool coverage.

(5) (a) The board shall establish and adjust, as necessary, health underwriting criteria based on:

(i) health condition; and

(ii) expected claims so that the expected claims are anticipated to remain within available funding.

(b) The board, with approval of the commissioner, may contract with one or more providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting criteria under Subsection (5)(a).

[~~(c) If an individual is denied coverage by the pool under the criteria established in Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage under Subsection 31A-30-108(3).~~]

(6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose individual health care insurance coverage was involuntarily terminated, is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii) and (x).

(b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the termination date of the previous individual health care insurance coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous individual coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived to the extent to which the waiting period was satisfied under the individual health insurance plan.

Section 49. Section **31A-29-115** is amended to read:

31A-29-115. Cancellation -- Notice.

(1) [~~(a)~~] On the date of renewal, the pool may cancel an enrollee's policy if:

[~~(i)~~] (a) the enrollee's health condition does not meet the criteria established in Subsection 31A-29-111(5); and

[~~(ii)~~] (b) the pool has provided written notice to the enrollee's last-known address no less than 60 days before cancellation[~~; and~~].

[~~(iii) at least one individual carrier has not reached the individual enrollment cap established in Section 31A-30-110.~~]

[~~(b) The pool shall issue a certificate of insurability to an enrollee whose policy is cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the~~

~~requirements of Subsection 31A-29-111(5) are met.~~]

(2) The pool may cancel an enrollee's policy at any time if:

(a) the pool has provided written notice to the enrollee's last-known address no less than 15 days before cancellation; and

(b) (i) the enrollee establishes a residency outside of Utah for three consecutive months;

(ii) there is nonpayment of premiums; or

(iii) the pool determines that the enrollee does not meet the eligibility requirements set forth in Section 31A-29-111, in which case:

(A) the policy may be retroactively terminated for the period of time in which the enrollee was not eligible;

(B) retroactive termination may not exceed three years; and

(C) the board's remedy under this Subsection (2)(b) shall be a cause of action against the enrollee for benefits paid during the period of ineligibility in accordance with Subsection 31A-29-119(3).

Section 50. Section **31A-30-102** is amended to read:

31A-30-102. Purpose statement.

The purpose of this chapter is to:

(1) prevent abusive rating practices;

(2) require disclosure of rating practices to purchasers;

(3) establish rules regarding:

(a) a universal individual and small group application; and

(b) renewability of coverage;

(4) improve the overall fairness and efficiency of the individual and small group insurance market;

(5) provide increased access for individuals and small employers to health insurance; and

(6) provide an employer with the opportunity to establish a defined contribution

arrangement for an employee to purchase a health benefit plan through the [~~Internet portal~~] Health Insurance Exchange created by Section 63M-1-2504.

Section 51. 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 [~~Sections 31A-30-106 and 31A-30-106.1~~] 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 [~~any entity or~~] a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified [~~entity or~~] 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);

(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 [~~any~~] a person [~~or entity~~] 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) [~~any other~~] another person [~~or entity~~] 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) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.~~]

[~~(9)~~] (8) "Covered carrier" means [~~any~~] an individual carrier or small employer carrier subject to this chapter.

[~~(10)~~] (9) "Covered individual" means [~~any~~] an individual who is covered under a health benefit plan subject to this chapter.

[~~(11)~~] (10) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

[~~(12)~~] (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.

[~~(13)~~] (12) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

[~~(14)~~] (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.

[~~(15)~~] (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.

[~~(16)~~] (15) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

[~~(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.~~]

[~~(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.~~]

[~~(19)~~] (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.

[~~(20)~~] (17) "Premium" means money paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including [~~any~~] fees or other contributions associated with the health benefit plan.

[~~(21)~~] (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.

[~~(22) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.~~]

[~~(23)~~] (19) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

[~~(24)~~] (20) "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.

[~~(25) "Uninsurable" means an individual who:~~]

[~~(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or~~]

[~~(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and~~]

[~~(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g) and (h) for which coverage the applicant is applying.~~]

[~~(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:~~]

[~~(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and~~]

[~~(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.~~]

Section 52. Section **31A-30-104** is amended to read:

31A-30-104. Applicability and scope.

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small employers, except as provided in Subsection (3); or

(iii) both Subsections (1)(a)(i) and (ii); or

(b) individual conversion policy for purposes of Sections 31A-30-106.5 and 31A-30-107.5.

(2) This chapter applies to a health benefit plan that provides coverage to small employers or individuals regardless of:

(a) whether the contract is issued to:

(i) an association, except as provided in Subsection (3);

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the situs of delivery of the policy or contract.

(3) This chapter does not apply to:

(a) short-term limited duration health insurance;

(b) federally funded or partially funded programs; or

(c) a bona fide employer association.

(4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

(i) carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier; and

(ii) any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated carriers were issued by one carrier.

(b) Upon a finding of the commissioner, an affiliated carrier that is a health maintenance organization having a certificate of authority under this title may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to covered insureds in this state if the ceding arrangements would result in less than 50% of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier.

(d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to covered insureds in this state.

(5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act, or a carrier with the written authorization of such a trust,

may make a written request to the commissioner for a waiver from the application of any of the provisions of [~~Subsection~~] Subsections 31A-30-106(1) and 31A-30-106.1(1) with respect to a health benefit plan provided to the trust.

(b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a waiver if the commissioner finds that application with respect to the trust would:

(i) have a substantial adverse effect on the participants and beneficiaries of the trust; and

(ii) require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

(c) A waiver granted under this Subsection (5) may not apply to an individual if the person participates in a Taft Hartley trust as an associate member of any employee organization.

(6) Sections 31A-30-106, 31A-30-106.1, 31A-30-106.5, 31A-30-106.7, 31A-30-107, and 31A-30-108, [~~and 31A-30-111~~] apply to:

(a) any insurer engaging in the business of insurance related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit; and

(b) any contract of an insurer, other than a workers' compensation policy, related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit.

(7) The commissioner may make rules requiring that the marketing practices be consistent with this chapter for:

(a) a small employer carrier;

(b) a small employer carrier's agent;

(c) an insurance producer;

(d) an insurance consultant; and

(e) a navigator.

Section 53. Section **31A-30-106** is amended to read:

31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for health benefit plans for individuals under this chapter are subject to this section.

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) (i) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to the individual under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate except as provided under Subsection (1)(b)(ii).

(ii) A carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan.

(d) (i) A carrier offering an individual health benefit plan shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical individuals that:

(A) differ only by the amounts attributable to plan design; and

(B) do not reflect differences due to the nature of the individuals assumed to select particular health benefit products.

(iii) A carrier offering an individual health benefit plan shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(f) A carrier offering a health benefit plan to an individual may not, without prior approval of the commissioner, use case characteristics other than:

(i) age;

(ii) gender;

(iii) geographic area; and

(iv) family composition.

(g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(A) implement this chapter; [~~and~~]

(B) assure that rating practices used by carriers who offer health benefit plans to individuals are consistent with the purposes of this chapter[~~.~~]; and

(C) promote transparency of rating practices of health benefit plans, except that a carrier may not be required to disclose proprietary information.

(ii) The rules described in Subsection (1)(g)(i) may include rules that:

(A) assure that differences in rates charged for health benefit products by carriers who offer health benefit plans to individuals are reasonable and reflect objective differences in plan design, not including differences due to the nature of the individuals assumed to select particular health benefit products; and

(B) prescribe the manner in which case characteristics may be used by carriers who offer health benefit plans to individuals[~~;~~].

[~~(C) implement the individual enrollment cap under Section 31A-30-110, including specifying:~~]

[~~(I) the contents for certification;~~]

[~~(II) auditing standards;~~]

[~~(III) underwriting criteria for uninsurable classification; and~~]

[~~(IV) limitations on high risk enrollees under Section 31A-30-111; and~~]

[~~(D) establish the individual enrollment cap under Subsection 31A-30-110(1).~~]

[~~(h) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 325% of that expected for a standard insurable individual with the same case characteristics.~~]

[~~(i)~~] (h) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the covered carrier is actively enrolling new covered insureds.

(3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard to:

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b) (i) [~~Each~~] A carrier subject to this section shall file with the commissioner, on or before April 1 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the carrier is in compliance with this chapter; and

(B) the rating methods of the carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the carrier at the carrier's principal place of business.

(c) A carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) [~~Records~~] Except as provided in Subsection (1)(g) or required by PPACA, a record submitted to the commissioner under this section shall be maintained by the commissioner as a protected [~~records~~] record under Title 63G, Chapter 2, Government Records Access and Management Act.

Section 54. Section **31A-30-106.7** is amended to read:

31A-30-106.7. Surcharge for groups changing carriers.

(1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered carrier may impose upon a small group that changes coverage to that carrier from another carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could

otherwise charge under Section [~~31A-30-106~~] 31A-30-106.1.

(b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

(i) the change in carriers occurs on the anniversary of the plan year, as defined in Section 31A-1-301;

(ii) the previous coverage was terminated under Subsection 31A-30-107(3)(e); [~~or~~]

(iii) employees from an existing group form a new business[~~.~~]; and

(iv) the surcharge is not applied uniformly to all similarly situated small groups.

(2) A covered carrier may not impose the surcharge described in Subsection (1) if the offer to cover the group occurs at a time other than the anniversary of the plan year because:

(a) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) the offer to cover the group is not issued until after the anniversary date; or

(b) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) additional underwriting or rating information requested by the covered carrier is not received until after the anniversary date.

(3) If a covered carrier chooses to apply a surcharge under Subsection (1), the application of the surcharge and the criteria for incurring or avoiding the surcharge shall be clearly stated in the:

(a) written application materials provided to the applicant at the time of application; and

(b) written producer guidelines.

(4) The commissioner shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to ensure compliance with this section.

Section 55. Section **31A-30-107** is amended to read:

31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and nonrenewal.

(1) Except as otherwise provided in this section, a small employer health benefit plan is

renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A small employer health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if[~~: (i)~~] there is no longer any enrollee under the group health plan who lives, resides, or works in:

[~~(A)~~] (i) the service area of the covered carrier; or

[~~(B)~~] (ii) the area for which the covered carrier is authorized to do business; [~~and~~] or

[~~(ii) in the case of the small employer market, the small employer carrier applies the same criteria the small employer carrier would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or~~]

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A small employer health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular small employer health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other small employer health benefit products currently being offered by the small employer carrier in the market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's small employer health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's employer contribution requirements.

(5) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's minimum participation requirements.

(6) (a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

(7) For purposes of this section, a reference to "plan sponsor" includes a reference to

the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the small employer health benefit plan is made available by a covered carrier in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(8) A covered carrier may modify a small employer health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 56. Section **31A-30-108** is amended to read:

31A-30-108. Eligibility for small employer and individual market.

(1) (a) [~~Small employer carriers shall accept residents~~] A small employer carrier shall accept a small employer that applies for small group coverage as set forth in the Health Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a), and PPACA, Sec. 2702.

[~~(b) Individual carriers shall accept residents for individual coverage pursuant to:~~]

[~~(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and~~]

[~~(ii) Subsection (3).~~]

(b) An individual carrier shall accept an individual that applies for individual coverage as set forth in PPACA, Sec. 2702.

(2) (a) [~~Small~~] A small employer [~~carriers~~] carrier shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.

(b) [~~Small~~] A small employer [~~carriers~~] carrier may:

(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

[~~(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:~~]

[~~(a) the individual is not covered or eligible for coverage:~~]

[~~(i) (A) as an employee of an employer;~~]

[~~(B) as a member of an association; or~~]

[~~(C) as a member of any other group; and~~]

[~~(ii) under:~~]

[~~(A) a health benefit plan; or~~]

[~~(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;~~]

[~~(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:~~]

[~~(i) the Medicare program established under Title XVIII of the Social Security Act;~~]

[~~(ii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or~~]

[~~(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;~~]

[~~(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:~~]

[~~(i) Medicare supplement policy;~~]

[~~(ii) conversion option;~~]

[~~(iii) continuation or extension under COBRA; or~~]

[~~(iv) state extension;~~]

[~~(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b),~~

~~in which case, the requirement of this Subsection (3)(d) does not apply; and~~]

[~~(e) the individual is certified as ineligible for the Health Insurance Pool if:~~]

[~~(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111(5)(c); or~~]

[~~(ii) the individual applies for coverage with any individual carrier within 45 days after:~~]

[~~(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or~~]

[~~(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.~~]

[~~(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.~~]

[~~(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:~~]

[~~(i) cancellation of coverage under Subsection 31A-29-115(1); or~~]

[~~(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.~~]

[~~(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.~~]

[~~(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.~~]

[~~(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:~~]

[~~(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and~~]

[~~(ii) the commissioner finds that the carrier's issuance of new individual policies:~~]

[~~(A) is in the best interests of the state; and~~]

[~~(B) does not provide an unfair advantage to the carrier.~~]

[~~(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in Health Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).~~]

[~~(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the department.~~]

[~~(7) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:~~]

[~~(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and~~]

[~~(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:~~]

[~~(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and~~]

[~~(B) applies this section uniformly to all employers without regard to:~~]

[~~(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or~~]

[~~(II) any health status-related factor relating to an employee or dependent of an employee.~~]

[~~(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.~~]

[~~(ii) This Subsection (7)(b) does not:~~]

[~~(A) limit the small employer carrier's ability to renew coverage that is in force; or~~]

[~~(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.~~]

[~~(c) Coverage offered within a service area after the 180-day period specified in Subsection (7)(b) is subject to the requirements of this section.~~]

Section 57. Section **31A-30-207** is amended to read:

31A-30-207. Rating and underwriting restrictions for health plans in the defined contribution arrangement market.

(1) Except as provided in Subsection (2), rating and underwriting restrictions for defined contribution arrangement health benefit plans offered in the Health Insurance Exchange shall be in accordance with Section 31A-30-106.1, and the plan adopted under Chapter 42, Defined Contribution Risk Adjuster Act.

(2) Notwithstanding [~~the provisions of~~] Subsections 31A-30-106.1(9)(b)(ii) and (iii), a carrier offering a defined contribution arrangement in the Health Insurance Exchange under this part[~~: (a)~~] shall calculate rates based on a family tier rating structure that includes four tiers in compliance with Subsection 31A-30-106.1(9)(b)(i)[~~; and~~].

[~~(b) may not calculate rates based on a family tier rating structure that includes five or six tiers as described in Subsection 31A-30-106(9)(b)(ii) or (iii).~~]

(3) All insurers who participate in the defined contribution market shall:

(a) participate in the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

(b) provide the risk adjuster board with:

(i) an employer group's risk factor; and

(ii) carrier enrollment data; and

(c) submit rates to the exchange that are net of commissions.

(4) When an employer group enters the defined contribution arrangement market and the employer group has a health plan with an insurer who is participating in the defined contribution arrangement market, the risk factor applied to the employer group when it enters

the defined contribution arrangement market may not be greater than the employer group's renewal risk factor for the same group of covered employees and the same effective date, as determined by the employer group's insurer.

Section 58. Section **31A-30-209** is amended to read:

31A-30-209. Insurance producers and the Health Insurance Exchange.

(1) A producer may be listed on the Health Insurance Exchange as a credentialed producer [~~for the defined contribution arrangement market in accordance with Section 63M-1-2504,~~] if the producer is designated as [~~an appointed~~] a credentialed agent for the [~~defined contribution arrangement market~~] Health Insurance Exchange in accordance with Subsection (2).

(2) A producer whose license under this title authorizes the producer to sell [~~defined contribution arrangement health benefit plans may be appointed to the defined contribution arrangement market on~~] accident and health insurance may be credentialed by the Health Insurance Exchange [~~by the Insurance Department~~] and may sell any product on the Health Insurance Exchange, if the producer:

[~~(a) submits an application to the Insurance Department to be appointed as a producer for the defined contribution arrangement market on the Health Insurance Exchange;~~]

[~~(b) is an appointed agent in accordance with Subsection (3), for products offered in the defined contribution arrangement market of the Health Insurance Exchange, with the carriers that offer a defined contribution arrangement health benefit plan on the Health Insurance Exchange; and~~]

[~~(c) has completed continuing education for the defined contribution arrangement market that:~~]

[~~(i) is required by administrative rule adopted by the commissioner; and~~]

[~~(ii) provides training on premium assistance programs.~~]

(a) is an appointed producer with:

(i) all carriers that offer a plan in the defined contribution market on the Health Insurance Exchange; and

(ii) at least one carrier that offers a dental plan on the Health Insurance Exchange; and

(b) completes each year the Health Insurance Exchange training that includes training on premium assistance programs.

(3) A carrier shall appoint a producer to sell the carrier's products in the defined contribution arrangement market of the Health Insurance Exchange, within 30 days of the notice required in Subsection (3)(b), if:

(a) the producer is currently appointed by a majority of the carriers in the Health Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange; and

(b) the producer informs the carrier that the producer is:

(i) applying to be appointed to the defined contribution arrangement market in the Health Insurance Exchange;

(ii) appointed by a majority of the carriers in the defined contribution arrangement market in the Health Insurance Exchange;

(iii) willing to complete training regarding the carrier's products offered on the defined contribution arrangement market in the Health Insurance Exchange; and

(iv) willing to sign the contracts and business associate's agreements that the carrier requires for appointed producers in the Health Insurance Exchange.

Section 59. Section **31A-30-211** is amended to read:

31A-30-211. Insurer disclosure.

[~~(1) The Health Insurance Exchange shall provide an employer's producer with the group's risk factor used to calculate the employer group's premium at the time of:~~]

[~~(a) the initial offering of a health benefit plan; and~~]

[~~(b) the renewal of a health benefit plan.~~]

[~~(2) For health benefit plans that renew on or after March 1, 2012:~~]

(1) (a) [~~a~~] A carrier shall provide an employer and the employer's producer with premium renewal rates at least 60 days [~~prior to~~] before the group's renewal date for a plan offered under Part 1, Individual and Small Employer Group[~~; and~~].

(b) [~~the~~] The Health Insurance Exchange shall provide an employer and the employer's producer with premium renewal rates at least 60 days [~~prior to~~] before the group's renewal date for a plan offered under Part 2, Defined Contribution Arrangements.

[~~(3)~~] (2) An insurer does not have to provide additional notice of premium renewal rates to the employer or the employer's producer if the Health Insurance Exchange provides notice in accordance with Subsection [~~(2)~~] (1)(b).

Section 60. Section **31A-37-501** is amended to read:

31A-37-501. Reports to commissioner.

(1) A captive insurance company is not required to make a report except those provided in this chapter.

(2) (a) Before March 1 of each year, a captive insurance company shall submit to the commissioner a report of the financial condition of the captive insurance company, verified by oath of two of the executive officers of the captive insurance company.

(b) Except as provided in Sections 31A-37-204 and 31A-37-205, a captive insurance company shall report:

(i) using generally accepted accounting principles, except to the extent that the commissioner requires, approves, or accepts the use of a statutory accounting principle;

(ii) using a useful or necessary modification or adaptation to an accounting principle that is required, approved, or accepted by the commissioner for the type of insurance and kind of insurer to be reported upon; and

(iii) supplemental or additional information required by the commissioner.

(c) Except as otherwise provided:

(i) [~~an association captive insurance company and an industrial insured group~~] a licensed captive insurance company shall file the report required by Section 31A-4-113; and

(ii) an industrial insured group shall comply with Section 31A-4-113.5.

(3) (a) A pure captive insurance company may make written application to file the required report on a fiscal year end that is consistent with the fiscal year of the parent company of the pure captive insurance company.

(b) If the commissioner grants an alternative reporting date for a pure captive insurance company requested under Subsection (3)(a), the annual report is due 60 days after the fiscal year end.

(4) (a) Sixty days after the fiscal year end, a branch captive insurance company shall file with the commissioner a copy of [~~all~~] the reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath by two of the alien captive insurance company's executive officers.

(b) If the commissioner is satisfied that the annual report filed by the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed provides adequate information concerning the financial condition of the alien captive insurance company, the commissioner may waive the requirement for completion of the annual statement required for a captive insurance company under this section with respect to business written in the alien jurisdiction.

(c) A waiver by the commissioner under Subsection (4)(b):

(i) shall be in writing; and

(ii) is subject to public inspection.

Section 61. Section **31A-40-203** is amended to read:

31A-40-203. Covered employee.

(1) (a) An individual is a covered employee of a professional employer organization if the individual is coemployed pursuant to a professional employer agreement subject to this chapter.

(b) An individual who is a covered employee under a professional employer agreement is a covered [~~employer~~] employee, whether or not the professional employer organization provides the notice required by Subsection 31A-40-202(3), the earlier of the day on which:

(i) the employee is first compensated by the professional employer organization; or

(ii) the client notifies the professional employer organization of a new hire.

(2) An individual who is an officer, director, shareholder, partner, or manager of a client is a covered employee:

(a) to the extent that the client and the professional employer organization expressly agree in the professional employer agreement that the individual is a covered employee;

(b) if the conditions of Subsection (1) are met; and

(c) if the individual acts as an operational manager or performs day-to-day an operational service for the client.

Section 62. Section **31A-40-209** is amended to read:

31A-40-209. Workers' compensation.

(1) In accordance with Section 34A-2-103, a client is responsible for securing workers' compensation coverage for a covered employee.

(2) Subject to the requirements of Section 34A-2-103, if a professional employer organization obtains or assists a client in obtaining workers' compensation insurance pursuant to a professional employer agreement:

(a) the professional employer organization shall ensure that the client maintains and provides workers' compensation coverage for a covered employee in accordance with Subsection 34A-2-201(1) or (2) and rules of the Labor Commission, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) the workers' compensation coverage may show the professional employer organization as the named insured through a [~~multiple coordinated~~] master policy, if:

(i) the client is shown as an insured by means of an endorsement for each individual client;

(ii) the experience modification of a client is used; and

(iii) the insurer files the endorsement with the Division of Industrial Accidents as directed by a rule of the Labor Commission, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(c) at the termination of the professional employer agreement, if requested by the client, the insurer shall provide the client records regarding the loss experience related to workers' compensation insurance provided to a covered employee pursuant to the professional employer agreement; and

(d) the insurer shall notify a client if the workers' compensation coverage for the client is terminated.

(3) In accordance with Section 34A-2-105, the exclusive remedy provisions of Section 34A-2-105 apply to both the client and the professional employer organization under a professional employer agreement regulated under this chapter.

(4) Notwithstanding the other provisions in this section, an insurer may choose whether to issue:

(a) a policy for a client; or

(b) a [~~multiple coordinated~~] master policy with the client shown as an additional insured by means of an individual endorsement.

Section 63. Section **31A-42-202** is amended to read:

31A-42-202. Contents of plan.

(1) The board shall submit a plan of operation for the risk adjuster to the commissioner. The plan shall:

(a) establish the methodology for implementing:

(i) Subsection (2) for the defined contribution arrangement market established under Chapter 30, Part 2, Defined Contribution Arrangements; and

(ii) the participation of small employer group defined contribution arrangement health benefit plans;

(b) establish regular times and places for meetings of the board;

(c) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;

(d) contain additional provisions necessary and proper for the execution of the powers and duties of the risk adjuster; and

(e) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred.

(2) (a) The plan adopted by the board for the defined contribution arrangement market shall include:

(i) parameters an employer may use to designate eligible employees for the defined contribution arrangement market; and

(ii) underwriting mechanisms and employer eligibility guidelines:

(A) consistent with the federal Health Insurance Portability and Accountability Act; and

(B) necessary to protect insurance carriers from adverse selection in the defined contribution market.

(b) The plan required by Subsection (2)(a) shall outline how premium rates for a qualified individual in the defined contribution arrangement market are determined, including:

(i) the identification of an initial rate for a qualified individual based on:

(A) standardized age bands submitted by participating insurers; and

(B) wellness incentives for the individual as permitted by federal law; and

(ii) the identification of a group risk factor to be applied to the initial age rate of a qualified individual based on the health conditions of all qualified individuals in the same employer group and, for small employers, in accordance with Sections 31A-30-105 and 31A-30-106.1.

(c) The plan adopted under Subsection (2)(a) for the defined contribution arrangement market shall outline how:

(i) premium contributions for qualified individuals shall be submitted to the Health Insurance Exchange in the amount determined under Subsection (2)(b); and

(ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by qualified individuals within an employer group based on each individual's rating factor determined in accordance with the plan.

(d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting risk between defined contribution arrangement market insurers that:

(i) identifies health care conditions subject to risk adjustment;

(ii) establishes an adjustment amount for each identified health care condition;

(iii) determines the extent to which an insurer has more or less individuals with an identified health condition than would be expected; and

(iv) computes all risk adjustments.

(e) The board may amend the plan if necessary to:

(i) maintain the proper functioning and solvency of the defined contribution arrangement market and the risk adjuster mechanism;

(ii) mitigate significant issues of risk selection; or

(iii) improve the administration of the risk adjuster mechanism.

(3) The board shall establish a mechanism in which the <u>defined contribution arrangement market</u> participating carriers shall submit their plan base rates, rating factors, and premiums to the commissioner for an actuarial review under [~~the provisions of~~] Section 31A-30-115 [~~prior to~~] <u>before</u> the publication of the premium rates on the Health Insurance Exchange.

Section 64. Section **31A-43-102** is amended to read:

31A-43-102. Definitions.

For purposes of this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer is in compliance with [~~the provisions of~~] this chapter, based upon the individual's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the stop-loss insurer in establishing attachment points and other applicable determinations in conjunction with the provision of stop-loss insurance coverage.

(2) "Aggregate attachment point" means the dollar amount [~~in losses for eligible expenses~~] <u>of covered claims</u> incurred by a small employer plan beyond which the stop-loss insurer incurs liability for [~~all or part of the~~] losses incurred by the small employer plan, subject to limitations included in the contract.

(3) "Coverage" means the combination of the employer plan design and the stop-loss contract design.

(4) "Expected claims" means the amount of claims that, in the absence of [~~a~~] <u>aggregate</u>

stop-loss [~~contract~~] insurance, are projected to be incurred by a small employer health plan using reasonable and accepted actuarial principles.

(5) "Lasering":

(a) means increasing or removing stop-loss coverage for a specific individual within an employer group; and

(b) includes other practices that are prohibited by the commissioner by administrative rule that result in lowering the stop-loss premium for the employer by transferring the risk for an [~~individual~~] individual's claims back to the employer.

(6) "Small employer" means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

(7) "Specific attachment point" means the dollar amount [~~in losses for eligible expenses~~] of covered claims attributable to a single individual covered by a small employer plan in a contract year beyond which the stop-loss insurer assumes [~~all or part of~~] the liability for losses incurred by the small employer plan, subject to limitations included in the contract.

(8) "Stop-loss insurance" means insurance purchased by a small employer for which the stop-loss insurer assumes[~~, on a per-loss basis,~~] all loss amounts of the small employer's plan in excess of a stated amount, subject to the policy limit.

Section 65. Section **31A-43-301** is amended to read:

31A-43-301. Stop-loss insurance coverage standards.

(1) A small employer stop-loss insurance contract shall:

(a) be issued to the small employer to provide insurance to the group health benefit plan, not the employees of the small employer;

(b) use a standard application form developed by the commissioner by administrative rule;

(c) have a contract term with guaranteed rates for at least 12 months, without adjustment, unless there is a change in the benefits provided under the small employer's health plan during the contract period;

(d) include both a specific attachment point and an aggregate attachment point in a contract;

(e) align stop-loss plan benefit limitations and exclusions with a small employer's health plan benefit limitations and exclusions, including any annual or lifetime limits in the employer's health plan;

(f) have an annual specific attachment point that is at least $10,000;

(g) have an annual aggregate attachment point that may not be less than [~~90%~~] 85% of expected claims;

(h) pay stop-loss claims:

(i) incurred during the contract period; and

(ii) [~~submitted~~] paid within 12 months after the expiration date of the contract; and

(i) include provisions to cover incurred and unpaid claims if a small employer plan terminates.

(2) A small employer stop-loss contract shall not:

(a) include lasering; and

(b) pay claims directly to an individual employee, member, or participant.

Section 66. Section **31A-43-302** is amended to read:

31A-43-302. Stop-loss restrictions -- Filing requirements.

[~~(1) A stop-loss insurer shall demonstrate to the commissioner that the rates associated with specific and aggregate attachment points retained by a small employer group under the insurer's stop-loss plan are actuarially sound.~~]

[~~(2)~~] (1) A stop-loss insurer shall file the stop-loss insurance contract form and [~~rates~~] rate methodology with the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1 before the stop-loss insurance contract may be issued or delivered in the state.

[~~(3)~~] (2) A stop-loss insurer shall file with the commissioner, annually on or before April 1, in a form and manner required by the commissioner by administrative rule adopted by the commissioner:

(a) an actuarial memorandum and certification which demonstrates that the insurer is in compliance with this chapter; and

(b) the stop-loss insurer's stop-loss experience.

[~~(4) Each~~] (3) An insurer shall maintain at its principal place of business:

(a) a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate the rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles; and

(b) a copy of the [~~actuarial certification~~] annual filing required by Subsection [~~(3)~~] (2).

Section 67. Section **31A-43-303** is amended to read:

31A-43-303. Stop-loss insurance disclosure.

A stop-loss insurance contract delivered, issued for delivery, or entered into shall include the disclosure exhibit required by the commissioner through administrative rule, which shall include at least the following information:

(1) the complete costs for the stop-loss contract;

(2) the date on which the insurance takes effect and terminates, including renewability provisions;

(3) the aggregate attachment point and the specific attachment point;

(4) [~~any~~] limitations on coverage;

(5) an explanation of monthly accommodation and disclosure about any monthly accommodation features included in the stop-loss contract; [~~and~~]

(6) a description of terminal liability funding, including[~~: (a)~~] the cost of processing claims before and after the termination of the contract; and

[~~(b)~~] (7) maximum claims liability to the employer.

Section 68. Section **31A-43-304** is amended to read:

31A-43-304. Administrative rules.

The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(1) implement this chapter;

[~~(2) assure that differences in rates charged are reasonable and reflect objective differences in plan design;~~]

[~~(3)~~] (2) define lasering practices that are prohibited by this chapter;

[~~(4)~~] (3) establish the form and manner of the actuarial certification and the annual report on stop-loss experience required by Section 31A-43-302;

[~~(5)~~] (4) establish the form and manner of the disclosure required by Section 31A-43-303;

[~~(6)~~] (5) assure the rates associated with the specific attachment points and aggregate attachment points are actuarially sound and are not against the public interest; and

[~~(7)~~] (6) assure that stop-loss contracts include provisions to cover incurred and unpaid claims if a small employer plan terminates.

Section 69. Section **53-13-103** is amended to read:

53-13-103. Law enforcement officer.

(1) (a) "Law enforcement officer" means a sworn and certified peace officer who is an employee of a law enforcement agency that is part of or administered by the state or any of its political subdivisions, and whose primary and principal duties consist of the prevention and detection of crime and the enforcement of criminal statutes or ordinances of this state or any of its political subdivisions.

(b) "Law enforcement officer" specifically includes the following:

(i) any sheriff or deputy sheriff, chief of police, police officer, or marshal of any county, city, or town;

(ii) the commissioner of public safety and any member of the Department of Public Safety certified as a peace officer;

(iii) all persons specified in Sections 23-20-1.5 and 79-4-501;

(iv) any police officer employed by any college or university;

(v) investigators for the Motor Vehicle Enforcement Division;

(vi) investigators for the Department of Insurance, Fraud Division;

[~~(vi)~~] (vii) special agents or investigators employed by the attorney general, district attorneys, and county attorneys;

[~~(vii)~~] (viii) employees of the Department of Natural Resources designated as peace officers by law;

[~~(viii)~~] (ix) school district police officers as designated by the board of education for the school district;

[~~(ix)~~] (x) the executive director of the Department of Corrections and any correctional enforcement or investigative officer designated by the executive director and approved by the commissioner of public safety and certified by the division;

[~~(x)~~] (xi) correctional enforcement, investigative, or adult probation and parole officers employed by the Department of Corrections serving on or before July 1, 1993;

[~~(xi)~~] (xii) members of a law enforcement agency established by a private college or university provided that the college or university has been certified by the commissioner of public safety according to rules of the Department of Public Safety;

[~~(xii)~~] (xiii) airport police officers of any airport owned or operated by the state or any of its political subdivisions; and

[~~(xiii)~~] (xiv) transit police officers designated under Section 17B-2a-823.

(2) Law enforcement officers may serve criminal process and arrest violators of any law of this state and have the right to require aid in executing their lawful duties.

(3) (a) A law enforcement officer has statewide full-spectrum peace officer authority, but the authority extends to other counties, cities, or towns only when the officer is acting under Title 77, Chapter 9, Uniform Act on Fresh Pursuit, unless the law enforcement officer is employed by the state.

(b) (i) A local law enforcement agency may limit the jurisdiction in which its law enforcement officers may exercise their peace officer authority to a certain geographic area.

(ii) Notwithstanding Subsection (3)(b)(i), a law enforcement officer may exercise authority outside of the limited geographic area, pursuant to Title 77, Chapter 9, Uniform Act on Fresh Pursuit, if the officer is pursuing an offender for an offense that occurred within the limited geographic area.

(c) The authority of law enforcement officers employed by the Department of Corrections is regulated by Title 64, Chapter 13, Department of Corrections - State Prison.

(4) A law enforcement officer shall, prior to exercising peace officer authority:

(a) (i) have satisfactorily completed the requirements of Section 53-6-205; or

(ii) have met the waiver requirements in Section 53-6-206; and

(b) have satisfactorily completed annual certified training of at least 40 hours per year as directed by the director of the division, with the advice and consent of the council.

Section 70. Section **63J-1-602.2** is amended to read:

63J-1-602.2. List of nonlapsing funds and accounts -- Title 31 through Title 45.

(1) Appropriations from the Insurance Department Restricted Account created in Section 31A-3-103, except to the extent that Section 31A-3-103 makes the money received under that section free revenue.

[~~(1)~~] (2) Appropriations from the Technology Development Restricted Account created in Section 31A-3-104.

[~~(2)~~] (3) Appropriations from the Criminal Background Check Restricted Account created in Section 31A-3-105.

[~~(3)~~] (4) Appropriations from the Captive Insurance Restricted Account created in Section 31A-3-304, except to the extent that Section 31A-3-304 makes the money received under that section free revenue.

[~~(4)~~] (5) Appropriations from the Title Licensee Enforcement Restricted Account created in Section 31A-23a-415.

[~~(5)~~] (6) Appropriations from the Health Insurance Actuarial Review Restricted Account created in Section 31A-30-115.

[~~(6)~~] (7) Appropriations from the Insurance Fraud Investigation Restricted Account created in Section 31A-31-108.

[~~(7)~~] (8) Appropriations from the Underage Drinking Prevention Media and Education Campaign Restricted Account created in Section 32B-2-306.

[~~(8)~~] (9) The Youth Development Organization Restricted Account created in Section 35A-8-1903.

[~~(9)~~] (10) The Youth Character Organization Restricted Account created in Section 35A-8-2003.

[~~(10)~~] (11) Funding for a new program or agency that is designated as nonlapsing under Section 36-24-101.

[~~(11)~~] (12) Appropriations from the Oil and Gas Conservation Account created in Section 40-6-14.5.

[~~(12)~~] (13) Appropriations from the Electronic Payment Fee Restricted Account created by Section 41-1a-121 to the Motor Vehicle Division.

[~~(13)~~] (14) Funds available to the Tax Commission under Section 41-1a-1201 for the:

(a) purchase and distribution of license plates and decals; and

(b) administration and enforcement of motor vehicle registration requirements.

Section 71. **Repealer.**

This bill repeals:

Section **31A-30-110, Individual enrollment cap.**

Section **31A-30-111, Limitations on high risk enrollees.**

Section 72. **Appropriation.**

Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, for the fiscal year beginning July 1, 2014, and ending June 30, 2015, the Legislature appropriates the following sums of money from the funds or accounts indicated for the use and support of the government of the state of Utah. These are additions to amounts previously appropriated for fiscal year 2015.

To Insurance Department Administration

From General Fund Restricted-Insurance Department Restricted Account -$403,500

Schedule of Programs:

Administration	-$403,500

Section 73. **Effective date.**

This bill takes effect on May 13, 2014, except that the amendments to Section 31A-3-304 (Effective 07/01/15) take effect on July 1, 2015.

Section 74. **Revisor instructions.**

The Legislature intends that the Office of Legislative Research and General Counsel, in preparing the Utah Code database for publication, replace the language in Subsections 31A-22-305(10) and 31A-22-305.3(9), from "this bill" with the bill's designated chapter and section number in the Laws of Utah.