INSURANCE RELATED MODIFICATIONS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill modifies provisions related to insurance.

Highlighted Provisions:

This bill:

- modifies enforcement penalties and procedures;
- replaces the term "health benefit product" with "health benefit plan";
- clarifies that rules are made under Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
- addresses taxation;
- requires licensees who are foreign insurers to provide contact information and maintain certain records;
- modifies due date of insurer holding company filing;
- enacts the Risk Management and Own Risk and Solvency Assessment Act, including:
  - providing the scope of the chapter;
  - defining terms;
  - requiring a risk management framework;
  - requiring an own risk and solvency assessment;
  - providing for a summary report and its contents;
  - providing for exemptions;
  - addressing confidentiality;

- establishing sanctions; and
- providing a severability clause;

▸ addresses risk based capital provisions;

▸ addresses association groups;

▸ modifies accident and health insurance standards provisions;

▸ moves provision for when a child of a group member may be denied eligibility;

▸ clarifies preferred provider contract provisions;

▸ addresses when a person is required to provide information concerning an employer self-insured employee welfare benefit plan;

▸ moves provisions related to alcohol and drug dependency treatment;

▸ addresses groups eligible for group or blanket insurance;

▸ modifies provisions related to requirements for notice of termination;

▸ addresses scope of part of credit life and accident and health insurance;

▸ amends definitions under the Unclaimed Life Insurance and Annuity Benefits Act;

▸ provides for the assessment of forfeitures;

▸ provides for notice to a producer of the termination of appointment;

▸ addresses when an insurer has a contract with a licensee;

▸ imposes requirements related to flood insurance;

▸ addresses licensed compensation;

▸ provides for notice to a designee when an agency terminates the designation, including navigator agencies;

▸ addresses contracts with agencies;

▸ addresses contracts with individual title insurance producer or an agency title insurance producer;

▸ requires certain record keeping requirements;

▸ addresses reports from organizations licensed as adjusters;

▸ enacts provisions related to adjusters;

- modifies provisions related to captive insurers, including:
  - amending definitions;
  - addressing permissive areas of insurance;
  - addressing capital issues;
  - modifying provisions required for formation;
  - providing that captive insurance companies may cede risks to certain insurers;
  - addressing contributions to guaranty of insolvency funds; and
  - repealing provisions related to an association captive or industrial insured group;
- amends board of directors provisions under the Defined Contribution Risk Adjuster Act;
- imposes record retention requirements under the Continuing Care Provider Act;
- repeals the Voluntary Health Insurance Purchasing Alliance Act; and
- makes technical and conforming amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides retrospective operation.

Utah Code Sections Affected:

AMENDS:

16-6a-207, as last amended by Laws of Utah 2008, Chapter 363

16-6a-301, as enacted by Laws of Utah 2000, Chapter 300

31A-2-308, as last amended by Laws of Utah 2012, Chapter 253

31A-3-102, as last amended by Laws of Utah 2014, Chapter 435

31A-3-205, as enacted by Laws of Utah 2005, Chapter 123

31A-3-304, as last amended by Laws of Utah 2015, Chapter 244

31A-8-402.3, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425

31A-8-402.5, as last amended by Laws of Utah 2003, Chapter 252

31A-16-105, as last amended by Laws of Utah 2015, Chapter 244

31A-17-404, as last amended by Laws of Utah 2016, Chapter 138

31A-17-603, as last amended by Laws of Utah 2013, Chapter 319

31A-22-505, as enacted by Laws of Utah 1985, Chapter 242

31A-22-605, as last amended by Laws of Utah 2005, Chapter 78

31A-22-610.5, as last amended by Laws of Utah 2011, Chapter 297

31A-22-614.5, as last amended by Laws of Utah 2011, Chapter 284

31A-22-617, as last amended by Laws of Utah 2014, Chapters 290 and 300

31A-22-701, as last amended by Laws of Utah 2011, Chapter 284

31A-22-716, as last amended by Laws of Utah 2011, Chapters 284 and 297

31A-22-721, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425

31A-22-801, as last amended by Laws of Utah 2001, Chapter 116

31A-22-1902, as enacted by Laws of Utah 2015, Chapter 259

31A-23a-111, as last amended by Laws of Utah 2016, Chapter 138

31A-23a-115, as last amended by Laws of Utah 2009, Chapter 349

31A-23a-203, as last amended by Laws of Utah 2014, Chapters 290 and 300

31A-23a-302, as last amended by Laws of Utah 2012, Chapter 253

31A-23a-407, as last amended by Laws of Utah 2016, Chapter 314

31A-23a-412, as last amended by Laws of Utah 2012, Chapter 253

31A-23a-501, as last amended by Laws of Utah 2016, Chapter 138

31A-23b-102, as last amended by Laws of Utah 2014, Chapters 290 and 300

31A-23b-202.5, as enacted by Laws of Utah 2014, Chapter 425

31A-23b-209, as enacted by Laws of Utah 2013, Chapter 341

31A-23b-210, as enacted by Laws of Utah 2013, Chapter 341

31A-23b-401, as last amended by Laws of Utah 2016, Chapter 138

31A-26-209, as last amended by Laws of Utah 2004, Chapter 173

31A-26-210, as last amended by Laws of Utah 2009, Chapter 349
31A-26-213, as last amended by Laws of Utah 2016, Chapter 138
31A-30-106, as last amended by Laws of Utah 2014, Chapters 290 and 300
31A-30-106.1, as last amended by Laws of Utah 2012, Chapter 279
31A-30-107, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
31A-30-107.1, as last amended by Laws of Utah 2003, Chapter 252
31A-35-103, as last amended by Laws of Utah 2016, Chapter 234
31A-37-102, as last amended by Laws of Utah 2016, Chapter 138
31A-37-106, as last amended by Laws of Utah 2015, Chapter 244
31A-37-202, as last amended by Laws of Utah 2015, Chapter 244
31A-37-204, as last amended by Laws of Utah 2016, Chapter 138
31A-37-301, as last amended by Laws of Utah 2016, Chapter 348
31A-37-303, as last amended by Laws of Utah 2016, Chapter 138
31A-37-305, as enacted by Laws of Utah 2003, Chapter 251
31A-42-201, as last amended by Laws of Utah 2010, Chapters 10 and 68
31A-44-603, as enacted by Laws of Utah 2016, Chapter 270
53-2a-1102, as last amended by Laws of Utah 2015, Chapter 408
59-7-102, as last amended by Laws of Utah 2014, Chapters 376 and 435
59-9-101, as last amended by Laws of Utah 2016, Chapter 135
63G-2-302, as last amended by Laws of Utah 2016, Chapter 410

ENACTS:

31A-14-205.5, Utah Code Annotated 1953
31A-16a-101, Utah Code Annotated 1953
31A-16a-102, Utah Code Annotated 1953
31A-16a-103, Utah Code Annotated 1953
31A-16a-104, Utah Code Annotated 1953
31A-16a-105, Utah Code Annotated 1953

31A-16a-106, Utah Code Annotated 1953

31A-16a-107, Utah Code Annotated 1953

31A-16a-108, Utah Code Annotated 1953

31A-16a-109, Utah Code Annotated 1953

31A-16a-110, Utah Code Annotated 1953

31A-22-645, Utah Code Annotated 1953

31A-26-312, Utah Code Annotated 1953

31A-26-401, Utah Code Annotated 1953

31A-26-402, Utah Code Annotated 1953

31A-26-403, Utah Code Annotated 1953

REPEALS:

31A-22-715, as last amended by Laws of Utah 2016, Chapter 138

31A-22-718, as enacted by Laws of Utah 1995, Chapter 344

31A-34-101, as enacted by Laws of Utah 1996, Chapter 143

31A-34-102, as enacted by Laws of Utah 1996, Chapter 143

31A-34-103, as enacted by Laws of Utah 1996, Chapter 143

31A-34-104, as last amended by Laws of Utah 2011, Chapter 297

31A-34-105, as last amended by Laws of Utah 2000, Chapter 300

31A-34-106, as enacted by Laws of Utah 1996, Chapter 143

31A-34-107, as last amended by Laws of Utah 2011, Chapter 297

31A-34-108, as last amended by Laws of Utah 2000, Chapter 300

31A-34-109, as enacted by Laws of Utah 1996, Chapter 143

31A-34-110, as last amended by Laws of Utah 2001, Chapter 108

31A-34-111, as enacted by Laws of Utah 1996, Chapter 143

31A-37-306, as last amended by Laws of Utah 2015, Chapter 244

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

Section 1. Section **16-6a-207** is amended to read:

16-6a-207. Incorporation of cooperative association.

(1) (a) If a cooperative association meets the requirements of Subsection (1)(b), it may:

(i) be incorporated under this chapter; and

(ii) use the word "cooperative" as part of its corporate or business name.

(b) A cooperative association described in Subsection (1)(a):

(i) may not be[~~: (A)~~] an association subject to the insurance or credit union laws of this state; and

[~~(B) a health insurance purchasing association as defined in Section 31A-34-103; or~~]

[~~(C) a health insurance purchasing alliance licensed under Title 31A, Chapter 34, Voluntary Health Insurance Purchasing Alliance Act; and~~]

(ii) shall state in its articles of incorporation that:

(A) a member may not have more than one vote regardless of the number or amount of stock or membership capital owned by the member unless voting is based in whole or in part on the volume of patronage of the member with the cooperative association; and

(B) savings in excess of dividends and additions to reserves and surplus shall be distributed or allocated to members or patrons on the basis of patronage.

(2) (a) Any cooperative association incorporated in accordance with Subsection (1):

(i) has all the rights and is subject to the limitations provided in Section 3-1-11; and

(ii) may pay dividends on its stock, if it has stock, subject to the limitations of Section 3-1-11.

(b) The articles of incorporation or the bylaws of a cooperative association incorporated in accordance with Subsection (1) may provide for:

(i) the establishment and alteration of voting districts;

(ii) the election of delegates to represent:

(A) the districts described in Subsection (2)(b)(i); and

(B) the members of the districts described in Subsection (2)(b)(i);

(iii) the establishment and alteration of director districts; and

(iv) the election of directors to represent the districts described in Subsection (2)(b)(ii) by:

(A) the members of the districts; or

(B) delegates elected by the members.

(3) (a) A corporation organized under Title 3, Uniform Agricultural Cooperative Association Act, or Title 16, Chapter 16, Uniform Limited Cooperative Association Act, may convert itself into a cooperative association subject to this chapter by adopting appropriate amendments to its articles of incorporation by which:

(i) it elects to become subject to this chapter; and

(ii) makes changes in its articles of incorporation that are:

(A) required by this chapter; and

(B) any other changes permitted by this chapter.

(b) The amendments described in Subsection (3)(a) shall be adopted and filed in the manner provided by the law then applicable to the cooperative nonprofit corporation.

[~~(4) Notwithstanding Subsection (1), a health insurance purchasing association may not use the word "cooperative" or "alliance" but may use the word "association."~~]

[~~(5)~~] (4) Except as otherwise provided in this section, a cooperative nonprofit corporation is subject to this chapter.

[~~(6)~~] (5) A corporation that is a cooperative under this chapter may convert to a limited cooperative association under Title 16, Chapter 16, Uniform Limited Cooperative Association Act, by complying with that chapter.

Section 2. Section **16-6a-301** is amended to read:

16-6a-301. Purposes.

(1) Every nonprofit corporation incorporated under this chapter that in its articles of incorporation has a statement meeting the requirements of Subsection 16-6a-202(3)(a) may engage in any lawful activity except for express limitations set forth in the articles of

incorporation.

(2) (a) A nonprofit corporation engaging in an activity that is subject to regulation under another statute of this state may incorporate under this chapter only if permitted by, and subject to all limitations of, the other statute.

(b) Without limiting Subsection (2)(a) and subject to Subsection (2)(c), an organization may not be organized under this chapter if the organization is subject to the:

(i) insurance laws of this state; or

(ii) laws governing depository institutions as defined in Section 7-1-103.

[~~(c) Notwithstanding Subsection (2)(b), the following may be organized under this chapter:~~]

[~~(i) a health insurance purchasing association as defined in Section 31A-34-103; and~~]

[~~(ii) a health insurance purchasing alliance licensed under Title 31A, Chapter 34, Voluntary Health Insurance Purchasing Alliance Act.~~]

Section 3. Section **31A-2-308** is amended to read:

31A-2-308. Enforcement penalties and procedures.

(1) (a) A person who violates any insurance statute or rule or any order issued under Subsection 31A-2-201(4) shall forfeit to the state twice the amount of any profit gained from the violation, in addition to any other forfeiture or penalty imposed.

(b) (i) The commissioner may order an individual producer, surplus line producer, limited line producer, managing general agent, reinsurance intermediary, adjuster, third party administrator, navigator, or insurance consultant who violates an insurance statute or rule to forfeit to the state not more than $2,500 for each violation.

(ii) The commissioner may order any other person who violates an insurance statute or rule to forfeit to the state not more than $5,000 for each violation.

(c) (i) The commissioner may order an individual producer, surplus line producer, limited line producer, managing general agent, reinsurance intermediary, adjuster, third party administrator, navigator, or insurance consultant who violates an order issued under Subsection

31A-2-201(4) to forfeit to the state not more than $2,500 for each violation. Each day the violation continues is a separate violation.

(ii) The commissioner may order any other person who violates an order issued under Subsection 31A-2-201(4) to forfeit to the state not more than $5,000 for each violation. Each day the violation continues is a separate violation.

(d) The commissioner may accept or compromise any forfeiture under this Subsection (1) until after a complaint is filed under Subsection (2). After the filing of the complaint, only the attorney general may compromise the forfeiture.

(2) When a person fails to comply with an order issued under Subsection 31A-2-201(4), including a forfeiture order, the commissioner may file an action in any court of competent jurisdiction or obtain a court order or judgment:

(a) enforcing the commissioner's order;

(b) (i) directing compliance with the commissioner's order and restraining further violation of the order; and

(ii) subjecting the person ordered to the procedures and sanctions available to the court for punishing contempt if the failure to comply continues; or

(c) imposing a forfeiture in an amount the court considers just, up to $10,000 for each day the failure to comply continues after the filing of the complaint until judgment is rendered.

(3) (a) The Utah Rules of Civil Procedure govern actions brought under Subsection (2), except that the commissioner may file a complaint seeking a court-ordered forfeiture under Subsection (2)(c) no sooner than two weeks after giving written notice of the commissioner's intention to proceed under Subsection (2)(c).

(b) The commissioner's order issued under Subsection 31A-2-201(4) may contain a notice of intention to seek a court-ordered forfeiture if the commissioner's order is disobeyed.

(4) If, after a court order is issued under Subsection (2), the person fails to comply with the commissioner's order or judgment:

(a) the commissioner may certify the fact of the failure to the court by affidavit; and

(b) the court may, after a hearing following at least five days written notice to the parties subject to the order or judgment, amend the order or judgment to add the forfeiture or forfeitures, as prescribed in Subsection (2)(c), until the person complies.

(5) (a) The proceeds of the forfeitures under this section, including collection expenses, shall be paid into the General Fund.

(b) The expenses of collection shall be credited to the department's budget.

(c) The attorney general's budget shall be credited to the extent the department reimburses the attorney general's office for its collection expenses under this section.

(6) (a) Forfeitures and judgments under this section bear interest at the rate charged by the United States Internal Revenue Service for past due taxes on the:

(i) date of entry of the commissioner's order under Subsection (1); or

(ii) date of judgment under Subsection (2).

(b) Interest accrues from the later of the dates described in Subsection (6)(a) until the forfeiture and accrued interest are fully paid.

(7) A forfeiture may not be imposed under Subsection (2)(c) if:

(a) at the time the forfeiture action is commenced, the person was in compliance with the commissioner's order; or

(b) the violation of the order occurred during the order's suspension.

(8) The commissioner may seek an injunction as an alternative to issuing an order under Subsection 31A-2-201(4).

(9) (a) A person is guilty of a class B misdemeanor if that person:

(i) intentionally violates:

(A) an insurance statute of this state; or

(B) an order issued under Subsection 31A-2-201(4);

(ii) intentionally permits a person over whom that person has authority to violate:

(A) an insurance statute of this state; or

(B) an order issued under Subsection 31A-2-201(4); or

(iii) intentionally aids any person in violating:

(A) an insurance statute of this state; or

(B) an order issued under Subsection 31A-2-201(4).

(b) Unless a specific criminal penalty is provided elsewhere in this title, the person may be fined not more than:

(i) $10,000 if a corporation; or

(ii) $5,000 if a person other than a corporation.

(c) If the person is an individual, the person may, in addition, be imprisoned for up to one year.

(d) As used in this Subsection (9), "intentionally" has the same meaning as under Subsection 76-2-103(1).

(10) (a) A person who knowingly and intentionally violates Section 31A-4-102, 31A-8a-208, 31A-15-105, 31A-23a-116, or 31A-31-111 is guilty of a felony as provided in this Subsection (10).

(b) When the value of the property, money, or other things obtained or sought to be obtained in violation of Subsection (10)(a):

(i) is less than $5,000, a person is guilty of a third degree felony; or

(ii) is or exceeds $5,000, a person is guilty of a second degree felony.

(11) (a) After a hearing, the commissioner may, in whole or in part, revoke, suspend, place on probation, limit, or refuse to renew the licensee's license or certificate of authority:

(i) when a licensee of the department, other than a domestic insurer:

(A) persistently or substantially violates the insurance law; or

(B) violates an order of the commissioner under Subsection 31A-2-201(4);

(ii) if there are grounds for delinquency proceedings against the licensee under Section 31A-27a-207; or

(iii) if the licensee's methods and practices in the conduct of the licensee's business endanger, or the licensee's financial resources are inadequate to safeguard, the legitimate

interests of the licensee's customers and the public.

(b) Additional license termination or probation provisions for licensees other than insurers are set forth in Sections 31A-19a-303, 31A-19a-304, 31A-23a-111, 31A-23a-112, 31A-25-208, 31A-25-209, 31A-26-213, 31A-26-214, 31A-35-501, and 31A-35-503.

(12) The enforcement penalties and procedures set forth in this section are not exclusive, but are cumulative of other rights and remedies the commissioner has pursuant to applicable law.

Section 4. Section **31A-3-102** is amended to read:

31A-3-102. Exclusive fees and taxes.

(1) The following are in place of any other license fee or license assessment that might otherwise be levied against a licensee by the state or a political subdivision of the state:

(a) taxes and fees under this chapter[~~,~~];

(b) the premium taxes under [~~Sections 59-9-101 through 59-9-104,~~] Title 59, Chapter 9, Taxation of Admitted Insurers;

(c) the fees under Section 31A-31-108[~~,~~]; and

(d) the examination costs under Section 31A-2-205 [~~are in place of all other license fees or assessments that might otherwise be levied by the state or any other taxing body within the state~~].

[~~(2) An~~]

(2) The following are not subject to Title 59, Chapter 7, Corporate Franchise and Income Taxes:

(a) an insurer that is subject to premium taxes under [~~Sections 59-9-101 through 59-9-104 is not subject to corporate franchise taxes.~~] Title 59, Chapter 9, Taxation of Admitted Insurers, regardless of whether the insurance company has a tax liability under that chapter;

(b) an insurance company that engages in a transaction that is subject to taxes under Section 31A-3-301 or 31A-3-302, regardless of whether the insurance company has a tax liability under that section; and

(c) a captive insurance company as provided in Section 31A-3-304 that pays a fee imposed under Section 31A-3-304.

(3) Unless otherwise exempt, a licensee under this title is subject to real and personal property taxes.

Section 5. Section **31A-3-205** is amended to read:

31A-3-205. Taxation of insurance companies.

(1) An admitted insurer shall pay to the State Tax Commission taxes imposed on the admitted insurer by Title 59, Revenue and Taxation.

(2) A surplus lines insurer shall pay the taxes due under Section 31A-3-301 or 31A-3-302 in accordance with Section 31A-3-303.

Section 6. Section **31A-3-304** is amended to read:

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

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

(b) The commissioner shall:

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

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

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

[~~(3) (a) 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:~~]

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

(i) a fee under this section;

(ii) a fee under Chapter 37, Captive Insurance Companies Act; [~~and~~] or

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

(b) The state or a county, city, or town within the state may not levy or collect an occupation tax or other [~~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 1 of each year.

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

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

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

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

(i) administer and enforce:

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

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

(ii) promote the captive insurance industry in Utah.

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

following shall be treated as free revenue in the General Fund:

(i) for fiscal year 2015-2016, in excess of $1,250,000;

(ii) for fiscal year 2016-2017, in excess of $1,250,000; and

(iii) for fiscal year 2017-2018 and subsequent fiscal years, in excess of $1,850,000.

Section 7. 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 for a network plan, if:

(a) there is no longer any enrollee under the group health plan who lives, resides, or works in:

(i) the service area of the insurer; or

(ii) the area for which the insurer is authorized to do business; 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~~] plan 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~~] plans currently being offered by the insurer in the market; or

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

(D) in exercising the option to discontinue that [~~product~~] health benefit plan 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 8. Section **31A-8-402.5** is amended to read:

31A-8-402.5. Individual discontinuance and nonrenewal.

(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all individuals or dependents; and

(ii) at the option of the individual.

(b) Subsection (1)(a) applies regardless of:

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

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

(a) for a network plan, if:

(i) the individual no longer lives, resides, or works in:

(A) the service area of the insurer; or

(B) the area for which the insurer is authorized to do business; and

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

(b) for coverage made available through an association, if:

(i) the individual'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 may be discontinued if:

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

(b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the individual:

(i) performs an act or practice in connection with the coverage 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~~] plan delivered or issued for delivery in this state; and

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

(I) to each individual provided coverage; 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 individuals;

(C) offers to each covered individual on a guaranteed issue basis, the option to purchase all other individual health benefit [~~products~~] plans currently being offered by the insurer for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans in the individual market; and

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

(I) to each individual provided coverage; 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 individuals;

(C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for issuance in the individual market; and

(D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

Section 9. Section **31A-14-205.5** is enacted to read:

31A-14-205.5. Place of business address information -- Record retention.

(1) (a) A licensee under this chapter shall register and maintain with the commissioner:

(i) the address and the one or more telephone numbers of the licensee's principal place of business; and

(ii) a valid business email address at which the commissioner may contact the licensee.

(b) A licensee shall notify the commissioner within 30 days of a change of any of the following required to be registered with the commissioner under this section:

(i) an address;

(ii) a telephone number; or

(iii) a business email address.

(2) (a) Except as provided under Subsection (3), a licensee under this chapter shall keep at the address of the principal place of business registered under Subsection (1), separate and distinct books and records of the transactions consummated under the Utah license.

(b) The books and records described in Subsection (2)(a) shall:

(i) be in an organized form; and

(ii) be available to the commissioner for inspection upon reasonable notice.

(c) The books and records described in Subsection (2)(a) shall include the following:

(i) if the licensee is a foreign insurer, alien insurer, commercially domiciled insurer, foreign title insurer, or foreign fraternal:

(A) a record of each insurance contract procured by or issued through the licensee, with the names of the one or more insureds, the amount of premium and commissions or other compensation, and the subject of the insurance;

(B) the name of any other producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary from whom business is accepted, and of a person to whom commissions or allowances of any kind are promised or paid; and

(C) a record of the consumer complaints forwarded to the licensee by an insurance regulator; and

(ii) any additional information that:

(A) is customary for a similar business; or

(B) may reasonably be required by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can be obtained immediately from a central storage place or elsewhere by online computer terminals located at the registered address.

(4) A licensee who represents only a single insurer satisfies Subsection (2) if the insurer maintains the books and records pursuant to Subsection (2) at a place satisfying Subsections (1) and (5).

(5) (a) The books and records maintained under Subsection (2) shall be available for the inspection of the commissioner during the business hours for a period of time after the date of the transaction as specified by the commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, but in no case for less than three calendar years in addition to the current calendar year.

(b) Discarding a book or record after the applicable record retention period has expired does not place the licensee in violation of a later-adopted longer record retention period.

Section 10. Section **31A-16-105** is amended to read:

31A-16-105. Registration of insurers.

(1) (a) An insurer that is authorized to do business in this state and that is a member of an insurance holding company system shall register with the commissioner, except a foreign

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

(b) An insurer that is subject to registration under this section shall register within 15 days after it becomes subject to registration, and annually thereafter by [~~May 1~~] June 30 of each year for the previous calendar year, unless the commissioner for good cause extends the time for registration and then at the end of the extended time period. The commissioner may require any insurer authorized to do business in the state, which is a member of a holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in Subsection (3), or any other information filed by the insurer with the insurance regulatory authority of domiciliary jurisdiction.

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

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

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

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

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

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

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

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

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

(vi) reinsurance agreements;

(vii) dividends and other distributions to shareholders; and

(viii) consolidated tax allocation agreements;

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

(e) if requested by the commissioner, financial statements of or within an insurance holding company system, including all affiliates:

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

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

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

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

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

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

(4) No information need be disclosed on the registration statement filed pursuant to Subsection (2) if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of 1%, or less, of an insurer's admitted assets as of the next preceding December 31 may not be considered material for purposes of this section.

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

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

(7) The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

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

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

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

(11) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer, or a disclaimer of affiliation may be filed by any insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material

relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation is considered to have been granted unless the commissioner, within 30 days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. If disallowed, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer is granted by the commissioner, or if the disclaimer is considered to have been approved.

(12) The ultimate controlling person of an insurer subject to registration shall also file an annual enterprise risk report. The annual enterprise risk report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company that could pose enterprise risk to the insurer. The annual enterprise risk report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(13) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for the filing is a violation of this section.

Section 11. Section **31A-16a-101** is enacted to read:

CHAPTER 16a. RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT ACT

31A-16a-101. Title -- Scope.

(1) This chapter is known as the "Risk Management and Own Risk and Solvency Assessment Act."

(2) This chapter applies to an insurer domiciled in this state unless exempt pursuant to Section 31A-16a-106.

Section 12. Section **31A-16a-102** is enacted to read:

31A-16a-102. Definitions.

As used in this chapter:

(1) "Insurance group," for the purpose of conducting an own risk and solvency assessment, means those insurers and affiliates included within an insurance holding company system as defined in Section 31A-1-301.

(2) "Insurer" means the same as that term is defined in Section 31A-1-301, except that it does not include agency, authority, or instrumentality of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

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

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

(5) "Own risk and solvency assessment" means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group, of the material and relevant risks associated with the insurer or insurance group's current business plan and the sufficiency of capital resources to support those risks.

Section 13. Section **31A-16a-103** is enacted to read:

31A-16a-103. Risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

Section 14. Section **31A-16a-104** is enacted to read:

31A-16a-104. Own risk and solvency assessment requirement.

Subject to Section 31A-16a-106, an insurer, or the insurance group of which the insurer

is a member, shall regularly conduct an own risk and solvency assessment consistent with a process comparable to the ORSA guidance manual. The insurer or insurance group shall conduct the own risk and solvency assessment no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

Section 15. Section **31A-16a-105** is enacted to read:

31A-16a-105. ORSA summary report.

(1) (a) Upon the commissioner's request, and no more than once each year, an insurer shall submit to the commissioner an ORSA summary report or any combination of reports that together contain the information described in the ORSA guidance manual, applicable to the insurer, the insurance group of which it is a member, or both.

(b) Notwithstanding a request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the one or more reports required by this Subsection (1) if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(2) The one or more reports required under Subsection (1) shall include a signature of the insurer's or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of the executive's belief and knowledge that:

(a) the insurer applies the enterprise risk management process described in the ORSA summary report; and

(b) a copy of the report has been provided to the insurer's board of directors or the appropriate committee of the board of directors.

(3) An insurer may comply with Subsection (1) by providing the most recent and substantially similar one or more reports provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a

supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA guidance manual. A report that is in a language other than English must be accompanied by a translation of that report into the English language.

Section 16. Section **31A-16a-106** is enacted to read:

31A-16a-106. Exemption.

(1) An insurer shall be exempt from the requirements of this chapter, if:

(a) the insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and

(b) the insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

(2) If an insurer qualifies for exemption pursuant to Subsection (1)(a), but the insurance group of which the insurer is a member does not qualify for exemption pursuant to Subsection (1)(b), the ORSA summary report that is required pursuant to Section 31A-16a-105 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA summary report for any combination of insurers provided any combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption pursuant to Subsection (1)(a), but the insurance group of which it is a member qualifies for exemption pursuant to Subsection (1)(b), the only ORSA summary report that may be required pursuant Section 31A-16a-105 shall be the report applicable to that insurer.

(4) An insurer that does not qualify for exemption pursuant to Subsection (1) may apply to the commissioner for a waiver from the requirements of this chapter based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the

commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(5) Notwithstanding the exemptions stated in this section:

(a) the commissioner may require that an insurer maintain a risk management framework, conduct an own risk and solvency assessment, and file an ORSA summary report based on unique circumstances, including the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests; or

(b) the commissioner may require that an insurer maintain a risk management framework, conduct an own risk and solvency assessment and file an ORSA summary report if the insurer has risk-based capital for company action level event as set forth in Sections 31A-17-601 through 31A-17-613, meets one or more of the standards of an insurer considered to be in hazardous financial condition as defined in Section 31A-27a-101, or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(6) If an insurer that qualifies for an exemption pursuant to Subsection (1) subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer has one calendar year following the calendar year the threshold is exceeded to comply with the requirements of this chapter.

Section 17. Section **31A-16a-107** is enacted to read:

31A-16a-107. Contents of ORSA summary report.

(1) The ORSA summary report shall be prepared consistent with the ORSA guidance manual, subject to the requirements of Subsection (2). Documentation supporting information

shall be maintained and made available upon examination or upon request of the commissioner.

(2) The review of the ORSA summary report, and any additional requests for information, shall be made using similar procedures as used in the analysis and examination of multi-state or global insurers and insurance groups.

Section 18. Section **31A-16a-108** is enacted to read:

31A-16a-108. Confidentiality.

(1) (a) A document, material, or other information, including the ORSA summary report, in the possession of or control of the department that is obtained by, created by, or disclosed to the commissioner or any other person under this chapter, is recognized by this state as being proprietary and to contain trade secrets. The document, material, or other information is confidential and may not be subject to Title 63G, Chapter 2, Government Records Access and Management Act, and may not be made public by the commissioner or any other person without the permission of the insurer.

(b) Notwithstanding Subsection (1)(a), the commissioner may use a document, material, or other information in furtherance of any regulatory or legal action brought as a part of the official duties. The commissioner may not otherwise make the document, material, or other information public without the prior written consent of the insurer.

(2) The commissioner and any person who receives a document, material, or other information related to an own risk and solvency assessment, through examination or otherwise, while acting under the authority of the commissioner or with whom the document, material, or other information is shared pursuant to this chapter shall keep the document, material, or other information confidential.

(3) To assist in the performance of the commissioner's regulatory duties, the commissioner:

(a) may, upon request, share a document, material, or other information related to an own risk solvency assessment, including a confidential document, material, or information

subject to Subsection (1), including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college as described in the Section 31A-16-108.5, with the National Association of Insurance Commissioners and with any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality of documents, materials, or other information related to an own risk and solvency assessment and has verified in writing the legal authority to maintain confidentiality;

(b) may receive a document, material, or other information related to an own risk and solvency assessment, including an otherwise confidential document, material, or information, including proprietary and trade secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as described in Section 31A-16-108.5 and from the National Association of Insurance Commissioners, and shall maintain as confidential a document, material, or information received with notice or the understanding that the document, material, or information is confidential under the laws of the jurisdiction that is the source of the document, material, or information; and

(c) shall enter into a written agreement with the National Association of Insurance Commissioners or a third-party consultant governing sharing and use of information provided pursuant to this chapter, consistent with this Subsection (3) that shall:

(i) specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this chapter, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state regulators from states in which the insurance group has domiciled insurers with the agreement providing that the recipient agrees in writing to maintain the confidentiality of a document, material, or other information related to an own risk and solvency assessment and verifies in writing the legal authority to maintain confidentiality;

(ii) specify that ownership of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this chapter remains with the commissioner, and that the National Association of Insurance Commissioners' or a third-party consultant's use of the information is subject to the direction of the commissioner;

(iii) prohibit the National Association of Insurance Commissioners or third-party consultant from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

(iv) require prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners or a third-party consultant pursuant to this chapter is subject to a request or subpoena to the National Association of Insurance Commissioners or a third-party consultant for disclosure or production;

(v) require the National Association of Insurance Commissioners or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or a third-party consultant may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this chapter; and

(vi) in the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(4) The sharing of information or a document by the commissioner pursuant to this chapter does not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of this chapter.

(5) A waiver of an applicable claim of confidentiality in a document, proprietary and trade-secret material, or other information related to an own risk and solvency assessment may not occur as a result of disclosure of the own risk and solvency assessment related information

or a document to the commissioner under this section or as a result of sharing as authorized in this chapter.

(6) A document, material, or other information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant pursuant to this chapter is:

(a) confidential, not a public record, and not open to public inspection; and

(b) not subject to Title 63G, Chapter 2, Government Records Access and Management Act.

Section 19. Section **31A-16a-109** is enacted to read:

31A-16a-109. Sanctions.

An insurer failing, without just cause, to timely file the ORSA summary report as required in this chapter is required, after notice and hearing, is subject to a penalty under Section 31A-2-308 for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the General Fund. The maximum penalty under this section is a penalty permitted under Section 31A-2-308. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Section 20. Section **31A-16a-110** is enacted to read:

31A-16a-110. Severability Clause.

If a provision of this chapter, or the application of this chapter to any person or circumstance, is held invalid, the invalidation does not affect the provisions or applications of this chapter that can be given effect without the invalid provision or application, and to that end the provisions of this chapter are severable.

Section 21. Section **31A-17-404** is amended to read:

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

(1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a

reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of Subsection (3), (4), (5), (6), (7), or (8), subject to the following:

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

(i) in its state of domicile; or

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

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

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

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

(b) only to the extent that the accounting:

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

(ii) clearly reflects:

(A) the amount and nature of risk transferred; and

(B) liability, including contingent liability, of the ceding insurer;

(c) only to the extent the reinsurance contract shifts insurance policy risk from the ceding insurer to the assuming reinsurer in fact and not merely in form; and

(d) only if the reinsurance contract contains a provision placing on the reinsurer the credit risk of all dealings with intermediaries regarding the reinsurance contract.

(3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state.

(b) An insurer is accredited as a reinsurer if the insurer:

(i) files with the commissioner evidence of the insurer's submission to this state's

jurisdiction;

(ii) submits to the commissioner's authority to examine the insurer's books and records;

(iii) (A) is licensed to transact insurance or reinsurance in at least one state; or

(B) in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(iv) files annually with the commissioner a copy of the insurer's:

(A) annual statement filed with the insurance department of its state of domicile; and

(B) most recent audited financial statement; and

(v) (A) (I) has not had its accreditation denied by the commissioner within 90 days of the day on which the insurer submits the information required by this Subsection (4); and

(II) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; or

(B) (I) has its accreditation approved by the commissioner; and

(II) maintains a surplus with regard to policyholders in an amount less than $20,000,000.

(c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation is revoked by the commissioner after a notice and hearing.

(5) (a) A domestic ceding insurer is allowed a credit if:

(i) the reinsurance is ceded to an assuming insurer that is:

(A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or

(B) in the case of a United States branch of an alien assuming insurer, is entered through a state meeting the requirements of Subsection (5)(a)(ii);

(ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for reinsurance substantially similar to those applicable under this section; and

(iii) the assuming insurer or United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; and

(B) submits to the authority of the commissioner to examine its books and records.

(b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded and assumed pursuant to a pooling arrangement among insurers in the same holding company system.

(6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund:

(i) created in accordance with rules made by the commissioner pursuant to Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) in a qualified United States financial institution for the payment of a valid claim of:

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; and

(C) a successor in interest to the United States ceding insurer.

(b) To enable the commissioner to determine the sufficiency of the trust fund described in Subsection (6)(a), the assuming insurer shall:

(i) report annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by a licensed insurer; and

(ii) (A) submit to examination of its books and records by the commissioner; and

(B) pay the cost of an examination.

(c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the form of the trust and any amendment to the trust is approved by:

(A) the commissioner of the state where the trust is domiciled; or

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

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

(iii) The trust instrument shall provide that a contested claim is valid and enforceable

upon the final order of a court of competent jurisdiction in the United States.

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

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; or

(C) a successor in interest to the United States ceding insurer.

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

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

(vii) No later than February 28 of each year, the trustee of the trust shall:

(A) report to the commissioner in writing the balance of the trust;

(B) list the trust's investments at the end of the preceding calendar year; and

(C) (I) certify the date of termination of the trust, if so planned; or

(II) certify that the trust will not expire prior to the following December 31.

(d) The following requirements apply to the following categories of assuming insurer:

(i) For a single assuming insurer:

(A) the trust fund shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and

(B) the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in Subsection (6)(d)(ii).

(ii) (A) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development.

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

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

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

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

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

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

(D) the incorporated members of the group:

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

(II) are subject to the same level of regulation and solvency control by the group's

domiciliary regulator as are the unincorporated members; and

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

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

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

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

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

(B) maintain aggregate policyholders' surplus of at least $10,000,000,000;

(C) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to a member of the group pursuant to a reinsurance contract issued in the name of the group;

(D) in addition to complying with the other provisions of this Subsection (6)(d)(iv), maintain a joint trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group as additional security for these liabilities; and

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

(I) an annual certification of each underwriter member's solvency by the member's domiciliary regulator; and

(II) a financial statement of each underwriter member of the group prepared by an independent public accountant.

(7) If reinsurance is ceded to an assuming insurer not meeting the requirements of

Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that secures its obligations in accordance with this Subsection (8):

(a) The insurer shall be certified by the commissioner as a reinsurer in this state.

(b) To be eligible for certification, the assuming insurer shall:

(i) be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to Subsection (8)(d);

(ii) maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(iii) maintain financial strength ratings from two or more rating agencies considered acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(iv) agree to:

(A) submit to the jurisdiction of this state;

(B) appoint the commissioner as its agent for service of process in this state;

(C) provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(D) agree to meet applicable information filing requirements as determined by the commissioner including an application for certification, a renewal and on an ongoing basis; and

(E) any other requirements for certification considered relevant by the commissioner.

(c) An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer. To be eligible for certification, in addition to satisfying requirements of Subsections (8)(a) and (b), the association:

(i) shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members in an amount determined by the commissioner to provide adequate protection;

(ii) may not have incorporated members of the association engaged in any business other than underwriting as a member of the association;

(iii) shall be subject to the same level of regulation and solvency control of the incorporated members of the association by the association's domiciliary regulator as are the unincorporated members; and

(iv) within 90 days after its financial statements are due to be filed with the association's domiciliary regulator provide:

(A) to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or

(B) if a certification is unavailable, financial statements prepared by independent public accountants, of each underwriter member of the association.

(d) The commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

(i) To determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:

(A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis;

(B) shall consider the rights, the benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States;

(C) shall require the qualified jurisdiction to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and

(D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards.

(ii) The commissioner may consider additional factors in determining a qualified jurisdiction.

(iii) A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners' Committee Process and the commissioner shall:

(A) consider this list in determining qualified jurisdictions; and

(B) if the commissioner approves a jurisdiction as qualified that does not appear on the National Association of Insurance Commissioner's list of qualified jurisdictions, provide thoroughly documented justification in accordance with criteria to be developed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(iv) United States jurisdictions that meet the requirement for accreditation under the National Association of Insurance Commissioners' financial standards and accreditation program shall be recognized as qualified jurisdictions.

(v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.

(e) The commissioner shall:

(i) assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies considered acceptable to the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) publish a list of all certified reinsurers and their ratings.

(f) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this Subsection (8) at a level consistent with its rating, as specified in rules made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(i) For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a multibeneficiary trust in accordance with Subsections (5), (6), and (7), except as otherwise provided in this Subsection (8).

(ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to Subsections (5), (6), and (7), and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this Subsection (8) or comparable laws of other United States jurisdictions and for its obligations subject to Subsections (5), (6), and (7).

(iii) It shall be a condition to the grant of certification under this Subsection (8) that the certified reinsurer shall have bound itself[~~,~~]:

(A) by the language of the trust and agreement with the commissioner with principal regulatory oversight of the trust account[~~,~~]; and

(B) upon termination of the trust account, to fund, [~~upon termination of the trust account,~~] out of the remaining surplus of the trust, any deficiency of any other [~~the~~] trust account.

(iv) The minimum trusteed surplus requirements provided in Subsections (5), (6), and (7) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this Subsection (8), except that the trust shall maintain a minimum trusteed surplus of $10,000,000.

(v) With respect to obligations incurred by a certified reinsurer under this Subsection (8), if the security is insufficient, the commissioner:

(A) shall reduce the allowable credit by an amount proportionate to the deficiency; and

(B) may impose further reductions in allowable credit upon finding that there is a

material risk that the certified reinsurer's obligations will not be paid in full when due.

(vi) For purposes of this Subsection (8), a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100% of its obligations.

(A) As used in this Subsection (8), the term "terminated" refers to revocation, suspension, voluntary surrender, and inactive status.

(B) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, the requirement under this Subsection (8)(f)(vi) does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(g) If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:

(i) defer to that jurisdiction's certification;

(ii) defer to the rating assigned by that jurisdiction; and

(iii) consider such reinsurer to be a certified reinsurer in this state.

(h) (i) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business.

(ii) An inactive certified reinsurer shall continue to comply with all applicable requirements of this Subsection (8).

(iii) The commissioner shall assign a rating to a reinsurer that qualifies under this Subsection (8)(h), that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(9) Reinsurance credit may not be allowed a domestic ceding insurer unless the assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

(a) (i) being an admitted insurer; and

(ii) submitting to jurisdiction under Section 31A-2-309;

(b) having irrevocably appointed the commissioner as the domestic ceding insurer's

agent for service of process in an action arising out of or in connection with the reinsurance, which appointment is made under Section 31A-2-309; or

(c) agreeing in the reinsurance contract:

(i) that if the assuming insurer fails to perform its obligations under the terms of the reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

(A) submit to the jurisdiction of a court of competent jurisdiction in a state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of an appellate court in the event of an appeal; and

(ii) to designate the commissioner or a specific attorney licensed to practice law in this state as its attorney upon whom may be served lawful process in an action, suit, or proceeding instituted by or on behalf of the ceding company.

(10) Submitting to the jurisdiction of Utah courts under Subsection (9) does not override a duty or right of a party under the reinsurance contract, including a requirement that the parties arbitrate their disputes.

(11) If an assuming insurer does not meet the requirements of Subsection (3), (4), or (5), the credit permitted by Subsection (6) or (8) may not be allowed unless the assuming insurer agrees in the trust instrument to the following conditions:

(a) (i) Notwithstanding any other provision in the trust instrument, if an event described in Subsection (11)(a)(ii) occurs the trustee shall comply with:

(A) an order of the commissioner with regulatory oversight over the trust; or

(B) an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(ii) This Subsection (11)(a) applies if:

(A) the trust fund is inadequate because the trust contains an amount less than the amount required by Subsection (6)(d); or

(B) the grantor of the trust is:

(I) declared insolvent; or

(II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the laws of its state or country of domicile.

(b) The assets of a trust fund described in Subsection (11)(a) shall be distributed by and a claim shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of a domestic insurance company.

(c) If the commissioner with regulatory oversight determines that the assets of the trust fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust instrument.

(d) A grantor shall waive any right otherwise available to it under United States law that is inconsistent with this Subsection (11).

(12) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

(a) The commissioner shall give the reinsurer notice and opportunity for hearing.

(b) The suspension or revocation may not take effect until after the commissioner's order after a hearing, unless:

(i) the reinsurer waives its right to hearing;

(ii) the commissioner's order is based on:

(A) regulatory action by the reinsurer's domiciliary jurisdiction; or

(B) the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state under Subsection (8)(g); or

(iii) the commissioner's finding that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(c) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 31A-17-404.1.

(d) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with Subsection (8)(f) or Section 31A-17-404.1.

(13) (a) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business.

(b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers:

(A) exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders; or

(B) after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding insurer's last reported surplus to policyholders.

(ii) The notification required by Subsection (13)(b)(i) shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(c) A ceding insurer shall take steps to diversify its reinsurance program.

(d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after ceding or being likely to cede more than 20% of the ceding insurer's gross written premium in the prior calendar year to any:

(A) single assuming insurer; or

(B) group of affiliated assuming insurers.

(ii) The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

Section 22. Section **31A-17-603** is amended to read:

31A-17-603. Company action level event.

(1) "Company action level event" means any of the following events:

(a) the filing of an RBC report by an insurer or health organization that indicates that:

(i) the insurer's or health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) if a life [~~or~~] insurer, accident and health insurer, or health organization, the insurer [~~has~~] or health organization:

(A) has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the life [~~or~~], fraternal, or health RBC instructions; or

(iii) if a property and casualty insurer, the insurer has:

(A) total adjusted capital that is greater than or equal to its company action level RBC, but less than the product of its authorized control level RBC and 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2) (a) In the event of a company action level event, the insurer or health organization shall prepare and submit to the commissioner an RBC plan that shall:

(i) identify the conditions that contribute to the company action level event;

(ii) contain proposals of corrective actions that the insurer or health organization intends to take and that are expected to result in the elimination of the company action level event;

(iii) provide projections of the insurer's or health organization's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of:

(A) statutory operating income;

(B) net income;

(C) capital;

(D) surplus; and

(E) RBC levels;

(iv) identify the key assumptions impacting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(v) identify the quality of, and problems associated with, the insurer's or health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(3) The RBC plan shall be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607, within 45 days after notification to the insurer or health organization that

after a hearing the commissioner rejects the insurer's or health organization's challenge.

(4) (a) Within 60 days after the submission by an insurer or health organization of an RBC plan to the commissioner, the commissioner shall notify the insurer or health organization whether the RBC plan:

(i) shall be implemented; or

(ii) is unsatisfactory.

(b) If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer or health organization shall set forth the reasons for the determination, and may propose revisions that will render the RBC plan satisfactory. Upon notification from the commissioner, the insurer or health organization shall:

(i) prepare a revised RBC plan that incorporates any revision proposed by the commissioner; and

(ii) submit the revised RBC plan to the commissioner:

(A) within 45 days after the notification from the commissioner; or

(B) if the insurer challenges the notification from the commissioner under Section 31A-17-607, within 45 days after a notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(5) In the event of a notification by the commissioner to an insurer or health organization that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may specify in the notification that the notification constitutes a regulatory action level event subject to the insurer's or health organization's right to a hearing under Section 31A-17-607.

(6) Every domestic insurer or health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer or health organization is authorized to do business if:

(a) the state has an RBC provision substantially similar to Subsection 31A-17-608(1);

and

(b) the insurance commissioner of that state notifies the insurer or health organization of its request for the filing in writing, in which case the insurer or health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3) and (4).

Section 23. Section **31A-22-505** is amended to read:

31A-22-505. Association groups.

(1) A policy is subject to the requirements of this section if the policy is issued as policyholder to an association or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations:

(a) with a minimum membership of 100 persons[~~,~~];

(b) with a constitution and bylaws[~~, and which~~];

(c) having a shared or common purpose that is not primarily a business or customer relationship; and

(d) that has been in active existence for at least two years[~~, is subject to the following requirements:~~].

[~~(1)~~] (2) The policy may insure members and employees of the association, employees of the members, one or more of the preceding entities, or all of any classes of these named entities for the benefit of persons other than the employees' employer, or any officials, representatives, trustees, or agents of the employer or association.

[~~(2)~~] (3) The premiums shall be paid by the policyholder from funds contributed by the associations, by employer members, from funds contributed by the covered persons, or from any combination of these. Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the covered persons, specifically for their insurance, is

required to insure all eligible persons.

Section 24. Section **31A-22-605** is amended to read:

31A-22-605. Accident and health insurance standards.

(1) The purposes of this section include:

(a) reasonable standardization and simplification of terms and coverages of individual and franchise accident and health insurance policies, including accident and health insurance contracts of insurers licensed under Chapter 7, Nonprofit Health Service Insurance Corporations, and Chapter 8, Health Maintenance Organizations and Limited Health Plans, to facilitate public understanding and comparison in purchasing;

(b) elimination of provisions contained in individual and franchise accident and health insurance contracts that may be misleading or confusing in connection with either the purchase of those types of coverages or the settlement of claims; and

(c) full disclosure in the sale of individual and franchise accident and health insurance contracts.

(2) As used in this section:

(a) "Direct response insurance policy" means an individual insurance policy solicited and sold without the policyholder having direct contact with a natural person intermediary.

(b) "Medicare" means the same as that term is defined in Subsection 31A-22-620(1)(e).

(c) "Medicare supplement policy" means the same as that term is defined in Subsection 31A-22-620(1)(f).

(3) This section applies to all individual and franchise accident and health policies.

(4) The commissioner shall adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, relating to the following matters:

(a) standards for the manner and content of policy provisions, and disclosures to be made in connection with the sale of policies covered by this section, dealing with at least the following matters:

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage provisions;

(iv) coverage of dependents;

(v) preexisting conditions;

(vi) termination of insurance;

(vii) probationary periods;

(viii) limitations;

(ix) exceptions;

(x) reductions;

(xi) elimination periods;

(xii) requirements for replacement;

(xiii) recurrent conditions;

(xiv) coverage of persons eligible for Medicare; and

(xv) definition of terms;

(b) minimum standards for benefits under each of the following categories of coverage in policies covered in this section:

(i) basic hospital expense coverage;

(ii) basic medical-surgical expense coverage;

(iii) hospital confinement indemnity coverage;

(iv) major medical expense coverage;

(v) income replacement coverage;

(vi) accident only coverage;

(vii) specified disease or specified accident coverage;

(viii) limited benefit health coverage; and

(ix) nursing home and long-term care coverage;

(c) the content and format of the outline of coverage, in addition to that required under Subsection (6);

(d) the method of identification of policies and contracts based upon coverages provided; and

(e) rating practices.

(5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine categories of coverage in [~~that subsection~~] Subsection (4)(b) provided that any combination of categories meets the standards of a component category of coverage.

(6) The commissioner may adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, relating to the following matters:

(a) establishing disclosure requirements for insurance policies covered in this section, designed to adequately inform the prospective insured of the need for and extent of the coverage offered, and requiring that this disclosure be furnished to the prospective insured with the application form, unless it is a direct response insurance policy;

(b) (i) prescribing caption or notice requirements designed to inform prospective insureds that particular insurance coverages are not Medicare Supplement coverages;

(ii) the requirements of Subsection (6)(b)(i) apply to all insurance policies and certificates sold to persons eligible for Medicare; and

(c) requiring the disclosures or information brochures to be furnished to the prospective insured on direct response insurance policies, upon his request or, in any event, no later than the time of the policy delivery.

(7) A policy covered by this section may be issued only if it meets the minimum standards established by the commissioner under Subsection (4), an outline of coverage accompanies the policy or is delivered to the applicant at the time of the application, and, except with respect to direct response insurance policies, an acknowledged receipt is provided to the insurer. The outline of coverage shall include:

(a) a statement identifying the applicable categories of coverage provided by the policy as prescribed under Subsection (4);

(b) a description of the principal benefits and coverage;

(c) a statement of the exceptions, reductions, and limitations contained in the policy;

(d) a statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;

(e) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(f) any other contents the commissioner prescribes.

(8) If a policy is issued on a basis other than that applied for, the outline of coverage shall accompany the policy when it is delivered and it shall clearly state that it is not the policy for which application was made.

(9) (a) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or certificates issued to persons eligible for Medicare shall contain a notice prominently printed on or attached to the cover or front page which states that the policyholder or certificate holder has the right to return the policy for any reason within 30 days after its delivery and to have the premium refunded.

(b) This Subsection (9) does not apply to a policy issued to an employer group.

Section 25. Section **31A-22-610.5** is amended to read:

31A-22-610.5. Dependent coverage.

(1) As used in this section, "child" has the same meaning as defined in Section 78B-12-102.

(2) (a) Any individual or group accident and health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent may not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday and shall, upon application, provide coverage for all unmarried dependents up to age 26.

(b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be included in the premium on the same basis as other dependent coverage.

(c) This section does not prohibit the employer from requiring the employee to pay all

or part of the cost of coverage for unmarried dependents.

(d) An individual health insurance policy, group health insurance policy, or health maintenance organization shall continue in force coverage for a dependent through the last day of the month in which the dependent ceases to be a dependent:

(i) if premiums are paid; and

(ii) notwithstanding Section 31A-8-402.3, 31A-8-402.5, 31A-22-721, 31A-30-107.1, or 31A-30-107.3.

(3) An individual or group accident and health insurance policy or health maintenance organization contract shall reinstate dependent coverage, and for purposes of all exclusions and limitations, shall treat the dependent as if the coverage had been in force since it was terminated; if:

(a) the dependent has not reached the age of 26 by July 1, 1995;

(b) the dependent had coverage prior to July 1, 1994;

(c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age of the dependent; and

(d) the policy has not been terminated since the dependent's coverage was terminated.

(4) (a) When a parent is required by a court or administrative order to provide health insurance coverage for a child, an accident and health insurer may not deny enrollment of a child under the accident and health insurance plan of the child's parent on the grounds the child:

(i) was born out of wedlock and is entitled to coverage under Subsection (5);

(ii) was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;

(iii) is not claimed as a dependent on the parent's federal tax return; or

(iv) does not reside with the parent or in the insurer's service area.

(b) A child enrolled as required under Subsection (4)(a)(iv) is subject to the terms of the accident and health insurance plan contract pertaining to services received outside of an

insurer's service area. A health maintenance organization shall comply with Section 31A-8-502.

(5) When a child has accident and health coverage through an insurer of a noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer shall:

(a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection (5)(a), whether the information is provided pursuant to a verbal or written request;

(b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) make payments on claims submitted in accordance with Subsection (5)(b) directly to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid agency.

(6) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program; and

(c) (i) when the child is covered by an individual policy, not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) the court or administrative order is no longer in effect; or

(B) the child is or will be enrolled in comparable accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment; or

(ii) when the child is covered by a group policy, not disenroll or eliminate coverage of the child unless the employer is provided with satisfactory written evidence, which evidence is also provided to the insurer, that Subsection (9)(c)(i), (ii) or (iii) has happened.

(7) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

(8) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.

(9) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:

(a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program;

(c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:

(i) the court order is no longer in effect;

(ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(iii) the employer has eliminated family health coverage for all of its employees; and

(d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.

(10) An order issued under Section 62A-11-326.1 may be considered a "qualified

medical support order" for the purpose of enrolling a dependent child in a group accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

(11) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:

(a) the parent continues to be eligible for coverage;

(b) the child shall be identified to the insurer with adequate information to comply with this section; and

(c) the premium shall be paid when due.

(12) [~~The provisions of this section apply~~] This section applies to employee welfare benefit plans as defined in Section 26-19-2.

[~~(13) The commissioner shall adopt rules interpreting and implementing this section with regard to out-of-area court ordered dependent coverage.~~]

(13) (a) A policy that provides coverage to a child of a group member may not deny eligibility for coverage to a child solely because:

(i) the child does not reside with the insured; or

(ii) the child is solely dependent on a former spouse of the insured rather than on the insured.

(b) A child who does not reside with the insured may be excluded on the same basis as a child who resides with the insured.

Section 26. Section **31A-22-614.5** is amended to read:

31A-22-614.5. Uniform claims processing -- Electronic exchange of health information.

(1) (a) Except as provided in Subsection (1)(c), [~~all insurers~~] an insurer offering health insurance shall use a uniform claim form and uniform billing and claim codes.

(b) Beginning January 1, 2011, all health benefit plans, and dental and vision plans, shall provide for the electronic exchange of uniform:

(i) eligibility and coverage information; and

(ii) coordination of benefits information.

(c) For purposes of Subsection (1)(a), "health insurance" does not include a policy or certificate that provides benefits solely for:

(i) income replacement; or

(ii) long-term care.

(2) (a) The uniform electronic standards and information required in Subsection (1) shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) When adopting rules under this section the commissioner:

(i) shall:

(A) consult with national and state organizations involved with the standardized exchange of health data, and the electronic exchange of health data, to develop the standards for the use and electronic exchange of uniform:

(I) claim forms;

(II) billing and claim codes;

(III) insurance eligibility and coverage information; and

(IV) coordination of benefits information; and

(B) meet federal mandatory minimum standards following the adoption of national requirements for transaction and data elements in the federal Health Insurance Portability and Accountability Act;

(ii) may not require an insurer or administrator to use a specific software product or vendor; and

(iii) may require an insurer who participates in the all payer database created under Section 26-33a-106.1 to allow data regarding demographic and insurance coverage information to be electronically shared with the state's designated secure health information master person index to be used:

(A) in compliance with data security standards established by:

(I) the federal Health Insurance Portability and Accountability Act; and

(II) the electronic commerce agreements established in a business associate agreement; and

(B) for the purpose of coordination of health benefit plans.

(3) (a) The commissioner shall coordinate the administrative rules adopted under the provisions of this section with the administrative rules adopted by the Department of Health for the implementation of the standards for the electronic exchange of clinical health information under Section 26-1-37. The department shall establish procedures for developing the rules adopted under this section, which ensure that the Department of Health is given the opportunity to comment on proposed rules.

(b) (i) The commissioner may provide information to health care providers regarding resources available to a health care provider to verify whether a health care provider's practice management software system meets the uniform electronic standards for data exchange required by this section.

(ii) The commissioner may provide the information described in Subsection (3)(b)(i) by partnering with:

(A) a not-for-profit, broad based coalition of state health care insurers and health care providers who are involved in the electronic exchange of the data required by this section; or

(B) some other person that the commissioner determines is appropriate to provide the information described in Subsection (3)(b)(i).

(c) The commissioner shall regulate any fees charged by insurers to the providers for:

(i) uniform claim forms;

(ii) electronic billing; or

(iii) the electronic exchange of clinical health information permitted by Section 26-1-37.

(4) This section does not require a person to provide information concerning an

employer self-insured employee welfare benefit plan as defined in 29 U.S.C. Sec. 1002(1).

Section 27. 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, 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 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 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 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~~] to 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 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) A health care provider licensed to treat 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) 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.

(10) This section does not apply to catastrophic mental health coverage provided in

accordance with Section 31A-22-625.

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

Section 28. Section **31A-22-645** is enacted to read:

31A-22-645. Alcohol and drug dependency treatment.

(1) An insurer offering a health benefit plan providing coverage for alcohol or drug dependency treatment may require an inpatient facility to be licensed by:

(a) (i) the Department of Human Services, under Title 62A, Chapter 2, Licensure of Programs and Facilities; or

(ii) the Department of Health; or

(b) for an inpatient facility located outside the state, a state agency similar to one described in Subsection (1)(a).

(2) For inpatient coverage provided pursuant to Subsection (1), an insurer may require an inpatient facility to be accredited by the following:

(a) the Joint Commission; and

(b) one other nationally recognized accrediting agency.

Section 29. Section **31A-22-701** is amended to read:

31A-22-701. Groups eligible for group or blanket insurance.

(1) As used in this section, "association group" means a lawfully formed association of individuals or business entities that:

(a) purchases insurance on a group basis on behalf of members; and

(b) is formed and maintained in good faith for purposes other than obtaining insurance.

(2) A group accident and health insurance policy may be issued to:

(a) a group:

(i) to which a group life insurance policy may be issued under Sections 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-506, 31A-22-507, and 31A-22-509; and

(ii) that is formed and maintained in good faith for a purpose other than obtaining insurance;

(b) an association group that:

(i) has been actively in existence for at least five years;

(ii) has a constitution and bylaws;

(iii) has a shared or common purpose that is not primarily a business or customer relationship;

[~~(iii)~~] (iv) is formed and maintained in good faith for purposes other than obtaining insurance;

[~~(iv)~~] (v) does not condition membership in the association group on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

[~~(v)~~] (vi) makes accident and health insurance coverage offered through the association group available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member;

[~~(vi)~~] (vii) does not make accident and health insurance coverage offered through the association group available other than in connection with a member of the association group; and

[~~(vii)~~] (viii) is actuarially sound; or

(c) a group specifically authorized by the commissioner under Section 31A-22-509, upon a finding that:

(i) authorization is not contrary to the public interest;

(ii) the group is actuarially sound;

(iii) formation of the proposed group may result in economies of scale in acquisition, administrative, marketing, and brokerage costs;

(iv) the insurance policy, insurance certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to insurance policies that are

otherwise available to similar groups;

(v) the group would not present hazards of adverse selection;

(vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided; and

(vii) the group is formed and maintained in good faith for a purpose other than obtaining insurance.

(3) A blanket accident and health insurance policy:

(a) covers a defined class of persons;

(b) may not be offered or underwritten on an individual basis;

(c) shall cover only a group that is:

(i) actuarially sound; and

(ii) formed and maintained in good faith for a purpose other than obtaining insurance; and

(d) may be issued only to:

(i) a common carrier or an operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to the person's travel status;

(ii) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;

(iii) an institution of learning, including a school district, a school jurisdictional unit, or the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering students, teachers, or employees;

(iv) a religious, charitable, recreational, educational, or civic organization, or branch of one of those organizations, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;

(v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;

(vi) a volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;

(vii) a newspaper or other publisher, as policyholder, covering its carriers;

(viii) an association, including a labor union, that has a constitution and bylaws and that is organized in good faith for purposes other than that of obtaining insurance, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; and

(ix) any other class of risks that, in the judgment of the commissioner, may be properly eligible for blanket accident and health insurance.

(4) The judgment of the commissioner may be exercised on the basis of:

(a) individual risks;

(b) a class of risks; or

(c) both Subsections (4)(a) and (b).

Section 30. Section **31A-22-716** is amended to read:

31A-22-716. Required provision for notice of termination.

(1) [~~Every~~] A policy for group or blanket accident and health coverage issued or renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30 days prior written notice of termination to each employee or group member and to notify each employee or group member of the employee's or group member's rights to continue coverage upon termination.

(2) An insurer's monthly notice to the policyholder of premium payments due shall include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers shall provide a sample notice to the policyholder at least once a year.

[~~(3) For the purpose of compliance with federal law and the Health Insurance Portability and Accountability Act, all health benefit plans, health insurers, and student health plans shall provide a certificate of creditable coverage to each covered person upon the person's termination from the plan as soon as reasonably possible.~~]

Section 31. 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 for a network plan, if:

(a) there is no longer any enrollee under the group health plan who lives, resides, or works in:

(i) the service area of the insurer; or

(ii) the area for which the insurer is authorized to do business; 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~~] plan 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~~] plans 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~~] health benefit plan 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 32. Section **31A-22-801** is amended to read:

31A-22-801. Scope of part.

(1) Except as provided under Subsection (2), all life insurance and accident and health insurance in connection with loans or other credit transactions are subject to this part.

(2) (a) Insurance written in connection with a [~~loan or other~~] credit transaction [~~of more than 10 years duration~~] is not subject to this part, but is subject to other provisions of this title[~~.~~], if the credit transaction is:

(i) secured by a first mortgage or deed of trust; and

(ii) made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for such a purpose.

(b) Isolated transactions on the part of an insurer that are not related to an agreement or

plan for insuring debtors of the creditor are not subject to this part.

Section 33. Section **31A-22-1902** is amended to read:

31A-22-1902. Definitions.

As used in this part:

(1) "Administrator" means the same as that term is defined in Section 67-4a-102.

(2) "Asymmetric conduct" means an insurer's use of the death master file or other similar database before July 1, 2015, in connection with searching for information regarding whether annuitants under the insurer's annuities might be deceased, but not in connection with whether the insureds under the insurer's policies might be deceased.

(3) (a) "Contract" means an annuity contract.

(b) "Contract" does not include an annuity used to fund an employment-based retirement plan or program when:

(i) the insurer does not perform the record keeping services; or

(ii) the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

(4) "Death master file" means the United States Social Security Administration's Death Master File or another database or service that is at least as comprehensive as the United States Social Security Administration's Death Master File for determining that a person has reportedly died.

(5) "Death master file match" means a search of a death master file that results in a match of the Social Security number, or the name and date of birth of an insured, annuity owner, or retained asset account holder.

[~~(6) "Knowledge of death" means:~~]

[~~(a) receipt of an original or valid copy of a certified death certificate; or~~]

[~~(b) a death master file match validated by the insurer in accordance with Subsection 31A-22-1903(1)(a).~~]

[~~(7)~~] (6) (a) "Policy" means a policy or certificate of life insurance that provides a death

benefit.

(b) "Policy" does not include:

(i) a policy or certificate of life insurance that provides a death benefit under an employee benefit plan:

(A) subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1002, as periodically amended; or

(B) under [~~any~~] a federal employee benefit program;

(ii) a policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement;

(iii) a policy or certificate of credit life or accidental death insurance; or

(iv) a policy issued to a group master policyholder for which the insurer does not provide record keeping services.

[~~(8)~~] (7) "Record keeping services" means those circumstances under which the insurer agrees with a group policy or contract customer to be responsible for obtaining, maintaining, and administering, in its own or its agents' systems, information about each individual insured under an insured's group insurance contract, or a line of coverage under the group insurance contract, at least the following information:

(a) social security number, or name and date of birth;

(b) beneficiary designation information;

(c) coverage eligibility;

(d) benefit amount; and

(e) premium payment status.

[~~(9)~~] (8) "Retained asset account" means [~~any~~] a mechanism whereby the settlement of proceeds payable under a policy or contract is accomplished by the insurer or an entity acting on behalf of the insurer by depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

Section 34. Section **31A-23a-111** is amended to read:

31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (5);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-23a-113; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which the license is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) A line of authority issued under this chapter remains in force until:

(a) the qualifications pertaining to a line of authority are no longer met by the licensee; or

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5);

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(iii) lapses under Section 31A-23a-113; or

(iv) is voluntarily surrendered; or

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors.

(5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke:

(A) a license; or

(B) a line of authority;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a line of authority;

(iii) limit in whole or in part:

(A) a license; or

(B) a line of authority; [~~or~~]

(iv) deny a license application[~~.~~];

(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

(vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and Subsection (5)(a)(v).

(b) The commissioner may take an action described in Subsection (5)(a) if the

commissioner finds that the licensee:

(i) is unqualified for a license or line of authority under Section 31A-23a-104, 31A-23a-105, or 31A-23a-107;

(ii) violates:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person in this state within 60 days after the day on which the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the insurance producer's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) violates an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;

(xi) obtains or attempts to obtain a license through misrepresentation or fraud;

(xii) improperly withholds, misappropriates, or converts money or properties received in the course of doing insurance business;

(xiii) intentionally misrepresents the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) life settlement;

(xiv) is convicted of a felony;

(xv) admits or is found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere:

(A) uses fraudulent, coercive, or dishonest practices; or

(B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has an insurance license, or its equivalent, denied, suspended, or revoked in another state, province, district, or territory;

(xviii) forges another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) improperly uses notes or another reference material to complete an examination for an insurance license;

(xx) knowingly accepts insurance business from an individual who is not licensed;

(xxi) fails to comply with an administrative or court order imposing a child support obligation;

(xxii) fails to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income

tax;

(xxiii) violates or permits others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is prohibited from engaging in the business of insurance; or

(xxiv) engages in a method or practice in the conduct of business that endangers the legitimate interests of customers and the public.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

(6) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(7) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in an order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval by the commissioner.

(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

(10) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 35. Section **31A-23a-115** is amended to read:

31A-23a-115. Appointment of individual and agency insurance producer, limited line producer, or managing general agent -- Reports and lists.

(1) (a) An insurer shall appoint an individual or agency with whom it has a contract as an insurance producer, limited line producer, or managing general agent to act on the insurer's behalf in order for the licensee to do business for the insurer in this state.

(b) An insurer shall report to the commissioner, at intervals and in the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(i) a new appointment; and

(ii) a termination of appointment.

(2) An insurer shall notify a producer that the producer's appointment is terminated by the insurer and of the reason for termination at an interval and in the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

[~~(2)~~] (3) (a) (i) An insurer shall report to the commissioner the cause of termination of an appointment if:

(A) the reason for termination is a reason described in Subsection 31A-23a-111(5)(b); or

(B) the insurer has knowledge that the individual or agency licensee is found to have engaged in an activity described in Subsection 31A-23a-111(5)(b) by:

(I) a court;

(II) a government body; or

(III) a self-regulatory organization, which the commissioner may define by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(ii) The information provided to the commissioner under this Subsection [~~(2)~~] (3) is a private record under Title 63G, Chapter 2, Government Records Access and Management Act.

(b) An insurer is immune from civil action, civil penalty, or damages if the insurer complies in good faith with this Subsection [~~(2)~~] (3) in reporting to the commissioner the cause of termination of an appointment.

(c) Notwithstanding any other provision in this section, an insurer is not immune from any action or resulting penalty imposed on the reporting insurer as a result of proceedings brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection [~~(2)~~] (3).

[~~(3)~~] (4) If an insurer appoints an agency, the insurer need not appoint, report, or pay appointment reporting fees for an individual designated on the agency's license under Section 31A-23a-302.

[~~(4)~~] (5) If an insurer has a contract with or lists a licensee in a report submitted under Subsection [~~(2)~~] (3), there is a rebuttable presumption that in placing a risk with the insurer the contracted or appointed licensee or any of the licensee's licensed employees act on behalf of the insurer.

Section 36. 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 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) (a) A resident producer with a property line of authority may only sell flood insurance coverage under the National Flood Insurance Program if the producer completes a minimum of three hours of flood insurance training related to the National Flood Insurance Program before selling flood insurance coverage.

(b) A course taken to satisfy a flood insurance training requirement may be used toward satisfying a producer continuing education requirement.

(c) Flood insurance training is not a continuing education requirement to renew a producer license.

(d) An insurer that issues flood insurance shall demonstrate to the commissioner, upon request, that a producer who is appointed by the insurer and who sells flood insurance coverage is in compliance with this Subsection (4).

[~~(4)~~] (5) The training periods required under this section apply only to an individual applying for a license under this chapter.

Section 37. Section **31A-23a-302** is amended to read:

31A-23a-302. Agency designations.

(1) An agency shall designate an individual that has an individual producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary license to act on the agency's behalf in order for the licensee to do business for the

agency in this state.

(2) An agency shall report to the commissioner, at intervals and in the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(a) a new designation; and

(b) a terminated designation.

(3) An agency shall notify an individual designee that the individual's designation is terminated by the agency and of the reason for termination at an interval and in the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

[~~(3)~~] (4) (a) An agency licensed under this chapter shall report to the commissioner the cause of termination of a designation if:

(i) the reason for termination is a reason described in Subsection 31A-23a-111(5)(b); or

(ii) the agency has knowledge that the individual licensee is found to have engaged in an activity described in Subsection 31A-23a-111(5)(b) by:

(A) a court;

(B) a government body; or

(C) a self-regulatory organization, which the commissioner may define by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) The information provided the commissioner under Subsection [~~(3)~~] (4)(a) is a private record under Title 63G, Chapter 2, Government Records Access and Management Act.

(c) An agency is immune from civil action, civil penalty, or damages if the agency complies in good faith with this Subsection [~~(3)~~] (4) in reporting to the commissioner the cause of termination of a designation.

(d) Notwithstanding any other provision in this section, an agency is not immune from an action or resulting penalty imposed on the reporting agency as a result of proceedings

brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection [~~(3)~~] (4).

[~~(4)~~] (5) An agency licensed under this chapter may act in a capacity for which it is licensed only through an individual who is licensed under this chapter to act in the same capacity.

[~~(5)~~] (6) An agency licensed under this chapter shall designate and report to the commissioner in accordance with any rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the name of the designated responsible licensed individual who has authority to act on behalf of the agency in the matters pertaining to compliance with this title and orders of the commissioner.

[~~(6)~~] (7) If an agency has a contract with or designates a licensee in reports submitted under Subsection (2) or [~~(5)~~] (6), there is a rebuttable presumption that the contracted or designated licensee acts on behalf of the agency.

[~~(7)~~] (8) (a) When a license is held by an agency, both the agency itself and any individual contracted or designated under the agency license shall be considered to be the holder of the agency license for purposes of this section.

(b) If an individual contracted or designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the agency license, or assessing a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i), the commissioner may assess a forfeiture, suspend, revoke, or limit the license of, or take a combination of these actions against:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for assessing a forfeiture, or suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection [~~(7)~~] (8)(b)(ii).

Section 38. Section **31A-23a-407** is amended to read:

31A-23a-407. Liability for acts of title insurance producers.

(1) Subject to the other provisions in this section, a title insurer that has a contract with or appoints an individual title insurance producer or an agency title insurance producer is liable to a buyer, seller, borrower, lender, or third party that deposits money with the individual title insurance producer or agency title insurance producer for the receipt and disbursement of money deposited with the individual title insurance producer or agency title insurance producer for a transaction when a commitment for a policy of title insurance of that title insurer is ordered, issued, or distributed or a title insurance policy of that title insurer is issued, except that once a title insurer is named in an issued commitment only that title insurer is liable as a title insurer under this section.

(2) The liability of a title insurer under Subsection (1) and the liability of an individual title insurance producer or agency title insurance producer for the receipt and disbursement of money deposited with the individual title insurance producer or agency title insurance producer is limited to the amount of money received and disbursed, not to exceed the amount of proposed insurance set forth in the commitment or title insurance policy described in Subsection (1) plus 10% of the amount of the proposed insurance.

(3) The liability described in Subsection (1) does not modify, mitigate, impair, or affect the contractual obligations between an individual title insurance producer or agency title insurance producer and the title insurer.

(4) The liability of a title insurer with respect to the condition of title to the real property that is the subject of a title insurance policy or a title insurance commitment for a title insurance policy is limited to the terms, conditions, and stipulations contained in the title insurance policy or title commitment.

Section 39. Section **31A-23a-412** is amended to read:

31A-23a-412. Place of business and residence address -- Records.

(1) (a) A licensee under this chapter shall register and maintain with the commissioner:

(i) the address and the one or more telephone numbers of the licensee's principal place of business; and

(ii) a valid business email address at which the commissioner may contact the licensee.

(b) If a licensee is an individual, in addition to complying with Subsection (1)(a) the individual shall register and maintain with the commissioner the individual's residence address and telephone number.

(c) A licensee shall notify the commissioner within 30 days of a change of any of the following required to be registered with the commissioner under this section:

(i) an address;

(ii) a telephone number; or

(iii) a business email address.

(2) (a) Except as provided under Subsection (3), a licensee under this chapter or an insurer under Chapter 14, Foreign Insurers, shall keep at the principal place of business address registered under Subsection (1), separate and distinct books and records of the transactions consummated under the Utah license.

(b) The books and records described in Subsection (2)(a) shall:

(i) be in an organized form;

(ii) be available to the commissioner for inspection upon reasonable notice; and

(iii) include all of the following:

(A) if the licensee is a producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary:

(I) a record of each insurance contract procured by or issued through the licensee, with the names of insurers and insureds, the amount of premium and commissions or other compensation, and the subject of the insurance;

(II) the names of any other producers, surplus lines producers, limited line producers, consultants, managing general agents, or reinsurance intermediaries from whom business is

accepted, and of persons to whom commissions or allowances of any kind are promised or paid; and

(III) a record of the consumer complaints forwarded to the licensee by an insurance regulator;

(B) if the licensee is a consultant, a record of each agreement outlining the work performed and the fee for the work; and

(C) any additional information which:

(I) is customary for a similar business; or

(II) may reasonably be required by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can be obtained immediately from a central storage place or elsewhere by on-line computer terminals located at the registered address.

(4) A licensee who represents only a single insurer satisfies Subsection (2) if the insurer maintains the books and records pursuant to Subsection (2) at a place satisfying Subsections (1) and (5).

(5) (a) The books and records maintained under Subsection (2) or Section 31A-23a-413 shall be available for the inspection of the commissioner during the business hours for a period of time after the date of the transaction as specified by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, but in no case for less than three calendar years in addition to the current calendar year [~~plus three years~~].

(b) Discarding [~~books and records~~] a book or record after the applicable record retention period has expired does not place the licensee in violation of a later-adopted longer record retention period.

Section 40. 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;

(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:

(A) the amount of any known noncommission compensation; and

(B) the type and amount, if known, of any potential and contingent 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:

(A) the amount of any known noncommission compensation;

(B) the type and amount, if known, of any potential and contingent noncommission compensation; and

(C) 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):

(i) "Large customer" means an employer who, with respect to a calendar year and to a plan year:

(A) employed an average of at least 100 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.

(ii) "Producer" includes:

(A) a producer;

(B) an affiliate of a producer; or

(C) 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 a large customer's initial purchase of the health benefit plan the producer discloses in writing to the large 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 large customer's signed acknowledgment that the disclosure under Subsection (4)(b) was made to the large customer; or

(ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to the large customer; and

(B) keep the signed statement on file in the producer's office while the health benefit plan placed with the large customer is in force.

(d) 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 large customer is in force, maintain a copy of:

(i) the signed acknowledgment described in Subsection (4)(c)(i); or

(ii) the signed statement described in Subsection (4)(c)(ii).

(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.

(f) (i) A producer shall provide to a large customer listed in this Subsection (4)(f) an annual accounting, as defined by rule made by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, of all amounts the producer receives in commission compensation from an insurer or third party administrator as a result of the sale or placement of a health benefit plan to a large customer that is:

(A) the state;

(B) a political subdivision or instrumentality of the state or a combination thereof primarily engaged in educational activities or the administration or servicing of educational activities, including the State Board of Education and its instrumentalities, an institution of higher education and its branches, a school district and its instrumentalities, a vocational and technical school, and an entity arising out of a consolidation agreement between entities

described under this Subsection (4)(f)(i)(B);

(C) a county, city, town, local district under Title 17B, Limited Purpose Local Government Entities - Local Districts, special service district under Title 17D, Chapter 1, Special Service District Act, an entity created by an interlocal cooperation agreement under Title 11, Chapter 13, Interlocal Cooperation Act, or any other governmental entity designated in statute as a political subdivision of the state; or

(D) a quasi-public corporation, that has the same meaning as defined in Section 63E-1-102.

(ii) The department shall pattern the annual accounting required by this Subsection (4)(f) on the insurance related information on Internal Revenue Service Form 5500 and its relevant attachments.

(g) At the request of the department, a producer shall provide the department a copy of:

(i) a disclosure required by this Subsection (4); or

(ii) an Internal Revenue Service Form 5500 and its relevant attachments.

(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 insurer, 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 41. 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)~~] (1) "Enroll" and "enrollment" mean to:

(a) (i) obtain personally identifiable information about an individual; and

(ii) inform an individual about accident and health insurance plans or public programs offered on an exchange;

(b) solicit insurance; or

(c) submit to the exchange:

(i) personally identifiable information about an individual; and

(ii) an individual's selection of a particular accident and health insurance plan or public program offered on the exchange.

[~~(3)~~] (2) (a) "Exchange" means an online marketplace that is certified by the United States Department of Health and Human Services as either a state-based small employer exchange or a federally facilitated individual exchange under PPACA.

(b) "Exchange" does not include an online marketplace for the purchase of health insurance if the online marketplace is not a certified exchange in accordance with Subsection [~~(3)~~] (2)(a).

[~~(4)~~] (3) "Navigator":

(a) means a person who facilitates enrollment in an exchange by offering to assist, or who advertises any services to assist, with:

(i) the selection of and enrollment in a qualified health plan or a public program offered on an exchange; or

(ii) applying for premium subsidies through an exchange; and

(b) includes a person who is an in-person assister or a certified application counselor as described in federal regulations or guidance issued under PPACA.

[~~(5)~~] (4) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

[~~(6)~~] (5) "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)~~] (6) "Resident" is as defined by rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

[~~(8)~~] (7) "Solicit" is as defined in Section 31A-23a-102.

Section 42. Section **31A-23b-202.5** is amended to read:

31A-23b-202.5. License types.

(1) A license issued under this chapter shall be issued under the license types described in Subsection (2).

(2) A license type under this chapter shall be a navigator line of authority or a certified application counselor line of authority. A license type is intended to describe the matters to be considered under any education, examination, and training required of an applicant under this chapter.

(3) (a) A navigator line of authority includes the enrollment process as described in Subsection 31A-23b-102[~~(4)~~](3)(a).

(b) (i) A certified application counselor line of authority is limited to providing information and assistance to individuals and employees about public programs and premium subsidies available through the exchange.

(ii) A certified application counselor line of authority does not allow the certified application counselor to assist a person with the selection of or enrollment in a qualified health plan offered on an exchange.

Section 43. Section **31A-23b-209** is amended to read:

31A-23b-209. Agency designations.

(1) An organization shall be licensed as a navigator agency if the organization acts as a navigator.

(2) A navigator agency that does business in the state shall designate an individual who is licensed under this chapter to act on the agency's behalf.

(3) A navigator agency shall report to the commissioner, at intervals and in the form

the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(a) a new designation under Subsection (2); and

(b) a terminated designation under Subsection (2).

(4) A navigator agency shall notify an individual designee that the individual's designation is terminated by the agency and of the reason for termination at an interval and in the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

[~~(4)~~] (5) (a) A navigator agency licensed under this chapter shall report to the commissioner the cause of termination of a designation if:

(i) the reason for termination is a reason described in Subsection 31A-23b-401(4)(b); or

(ii) the navigator agency has knowledge that the individual licensee engaged in an activity described in Subsection 31A-23b-401(4)(b) by:

(A) a court;

(B) a government body; or

(C) a self-regulatory organization, which the commissioner may define by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) The information provided to the commissioner under Subsection [~~(4)~~] (5)(a) is a private record under Title 63G, Chapter 2, Government Records Access and Management Act.

(c) A navigator agency is immune from civil action, civil penalty, or damages if the agency complies in good faith with this Subsection [~~(4)~~] (5) by reporting to the commissioner the cause of termination of a designation.

(d) A navigator agency is not immune from an action or resulting penalty imposed on the reporting agency as a result of proceedings brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection [~~(4)~~] (5).

[~~(5)~~] (6) A navigator agency licensed under this chapter may act in a capacity for which it is licensed only through an individual who is licensed under this chapter to act in the same capacity.

[~~(6)~~] (7) A navigator agency licensed under this chapter shall designate and report to the commissioner, in accordance with any rule made by the commissioner pursuant to Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the name of the designated responsible licensed individual who has authority to act on behalf of the navigator agency in the matters pertaining to compliance with this title and orders of the commissioner.

[~~(7)~~] (8) If a navigator agency has a contract with or designates a licensee in reports submitted under Subsection (3) or [~~(6)~~] (7), there is a rebuttable presumption that the contracted or designated licensee acts on behalf of the navigator agency.

[~~(8)~~] (9) (a) When a license is held by a navigator agency, both the navigator agency itself and any individual contracted or designated under the navigator agency license are considered the holders of the navigator agency license for purposes of this section.

(b) If an individual contracted or designated under the navigator agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the navigator agency license, or assessing a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i), the commissioner may assess a forfeiture, suspend, revoke, or limit the license of, or take a combination of these actions against:

(i) the individual;

(ii) the navigator agency, if the navigator agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license, or assessing a forfeiture; or

(iii) (A) the individual; and

(B) the navigator agency, if the agency meets the requirements of Subsection [~~(8)~~] (9)(b)(ii).

Section 44. Section **31A-23b-210** is amended to read:

31A-23b-210. Place of business and residence address -- Records.

(1) (a) A licensee under this chapter shall register and maintain with the commissioner:

(i) the address and the one or more telephone numbers of the licensee's principal place of business; and

(ii) a valid business email address at which the commissioner may contact the licensee.

(b) If a licensee is an individual, in addition to complying with Subsection (1)(a), the individual shall register and maintain with the commissioner the individual's residence address and telephone number.

(c) A licensee shall notify the commissioner within 30 days of a change of any of the following required to be registered with the commissioner under this section:

(i) an address;

(ii) a telephone number; or

(iii) a business email address.

(2) Except as provided under Subsection (3), a licensee under this chapter shall keep at the principal place of business address registered under Subsection (1), separate and distinct books and records of the transactions consummated under the Utah license.

(3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can be obtained immediately from a central storage place or elsewhere by online computer terminals located at the registered address.

(4) (a) The books and records maintained under Subsection (2) shall be available for the inspection by the commissioner during the business hours for a period of time after the date of the transaction as specified by the commissioner by rule, but in no case for less than the current calendar year plus three years.

(b) Discarding books and records after the applicable record retention period has expired does not place the licensee in violation of a later-adopted longer record retention period.

Section 45. Section **31A-23b-401** is amended to read:

31A-23b-401. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal or reinstatement.

(1) A license as a navigator 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 this section; 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[~~.~~];

(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

(vi) take a combination of actions under Subsections (4)(a)(i) through (iv) and Subsection (4)(a)(v).

(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-23b-204, 31A-23b-205, or 31A-23b-206;

(ii) 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) failed 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) refused:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(vi) had an officer who refused to:

(A) give information with respect to the navigator's affairs; or

(B) perform any other legal obligation as to an examination;

(vii) provided information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(viii) violated an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;

(ix) obtained or attempted to obtain a license through misrepresentation or fraud;

(x) improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

(xi) intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) application for public program;

(xii) is convicted of a felony;

(xiii) admitted or is found to have committed an insurance unfair trade practice or fraud;

(xiv) in the conduct of business in this state or elsewhere:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xv) had an insurance license, navigator license, or its equivalent, denied, suspended, or revoked in another state, province, district, or territory;

(xvi) forged another's name to:

(A) an application for insurance;

(B) a document related to an insurance transaction;

(C) a document related to an application for a public program; or

(D) a document related to an application for premium subsidies;

(xvii) improperly used notes or another reference material to complete an examination for a license;

(xviii) knowingly accepted insurance business from an individual who is not licensed;

(xix) failed to comply with an administrative or court order imposing a child support obligation;

(xx) failed to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxi) violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is prohibited from engaging in the business of insurance; or

(xxii) engaged in a method or practice in the conduct of business that endangered the legitimate interests of customers and the public.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (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) surrendered in lieu of administrative action;

(iv) lapsed; or

(v) 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 another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(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 an 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 chapter if so ordered by a 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 46. Section **31A-26-209** is amended to read:

31A-26-209. Form and contents of license.

(1) Licenses issued under this chapter shall be in the form the commissioner prescribes and shall set forth:

(a) the name, address, and the one or more telephone [~~number~~] numbers of the licensee;

(b) the license classifications under Section 31A-26-204;

(c) the date of license issuance; and

(d) any other information the commissioner considers advisable.

(2) An adjuster doing business under any other name than the adjuster's legal name shall notify the commissioner prior to using the assumed name in this state.

(3) (a) An organization shall be licensed as an agency if the organization acts as:

(i) an independent adjuster; or

(ii) a public adjuster.

(b) The agency license issued under Subsection (3)(a) shall set forth the names of all natural persons licensed under this chapter who are authorized to act in those capacities for the organization in this state.

Section 47. Section **31A-26-210** is amended to read:

31A-26-210. Reports from organizations licensed as adjusters.

(1) An organization licensed as an adjuster under Section 31A-26-203 shall designate an individual who has an individual adjuster license to act on the organization's behalf in order for the licensee to do business for the organization in this state.

(2) An organization licensed under this chapter shall report to the commissioner, at intervals and in the form the commissioner establishes by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(a) a new designation; and

(b) a terminated designation.

(3) An organization licensed under this chapter shall notify an individual licensee that the individual's designation has been terminated by the organization and of the reason for the termination at an interval and in the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

[~~(3)~~] (4) (a) An organization licensed under this chapter shall report to the commissioner the cause of termination of a designation if:

(i) the reason for termination is a reason described in Subsection 31A-26-213(5)(b); or

(ii) the organization has knowledge that the individual licensee is found to have engaged in an activity described in Subsection 31A-26-213(5)(b) by:

(A) a court;

(B) a government body; or

(C) a self-regulatory organization, which the commissioner may define by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) The information provided the commissioner under Subsection [~~(3)~~] (4)(a) is a private record under Title 63G, Chapter 2, Government Records Access and Management Act.

(c) An organization is immune from civil action, civil penalty, or damages if the organization complies in good faith with this Subsection [~~(3)~~] (4) in reporting to the commissioner the cause of termination of a designation.

(d) Notwithstanding any other provision in this section, an organization is not immune from an action or resulting penalty imposed on the reporting organization as a result of a proceeding brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection [~~(3)~~] (4).

[~~(4)~~] (5) An organization licensed under this chapter may act in a capacity for which it is licensed only through an individual who is licensed under this chapter to act in the same capacity.

[~~(5)~~] (6) An organization licensed under this chapter shall designate and report promptly to the commissioner the name of the designated responsible licensed individual who has authority to act on behalf of the organization in all matters pertaining to compliance with this title and orders of the commissioner.

[~~(6)~~] (7) If an agency has a contract with or designates a licensee in a report submitted under Subsection (2) or [~~(5)~~] (6), there is a rebuttable presumption that the contracted or designated licensee acts on behalf of the agency.

[~~(7)~~] (8) (a) When a license is held by an organization, both the organization itself and an individual contracted or designated under the license shall, for purposes of this section, be considered to be the holders of the organization license.

(b) If an individual designated under the organization license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the organization license, the commissioner may assess a forfeiture against, suspend, revoke, or limit the license of, or take a combination of these actions against:

(i) that individual;

(ii) the organization, if the organization:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for assessing a forfeiture or suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the organization, if the organization meets the requirements of Subsection [~~(7)~~] (8)(b)(ii).

Section 48. Section **31A-26-213** is amended to read:

31A-26-213. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (5);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-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[~~.~~];

(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

(vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and Subsection (5)(a)(v).

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license or 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 regulatory agency in any jurisdiction;

(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 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 49. Section **31A-26-312** is enacted to read:

31A-26-312. Prohibited conduct.

(1) An independent adjuster or public adjuster may not:

(a) participate directly or indirectly in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the independent adjuster or public adjuster;

(b) engage in any other activities that may reasonably be construed as presenting a conflict of interest, including soliciting or accepting remuneration from, or having a financial interest in, or deriving any direct or indirect financial benefit from, a salvage firm, repair firm, construction firm, or other firm that obtains business in connection with a claim that the independent adjuster or public adjuster has a contract or agreement to adjust;

(c) subject to Subsection (2), directly or indirectly solicit employment for an attorney or enter into a contract with an insured for the primary purpose of referring an insured to an

attorney and without actually performing the services customarily provided by an independent adjuster or public adjuster;

(d) act on behalf of an attorney in having an insured sign an attorney representation agreement; or

(e) accept a fee, commission, or other valuable consideration of any nature, regardless of form or amount, in exchange for the referral by an independent adjuster or public adjuster of an insured to a third-party person, including an attorney, appraiser, umpire, construction company, contractor, repair firm, or salvage company.

(2) Subsection (1)(c) may not be construed to prohibit an independent adjuster or public adjuster from recommending a specific attorney to an insured.

(3) An independent adjuster or public adjuster who violates this section is subject to Section 31A-2-308.

Section 50. Section **31A-26-401** is enacted to read:

Part 4. Public Adjusters

31A-26-401. Required contracts.

(1) A public adjuster may not, directly or indirectly, act within this state as a public adjuster without having first entered into a contract, in writing, on a form filed with the department in accordance with Section 31A-21-201, executed in duplicate by the public adjuster and the insured or the insured's duly authorized representative. A public adjuster may not use a form of contract that is not filed with the department.

(2) A contract described in Subsection (1) is subject to recision in accordance with Section 31A-26-311.

(3) (a) A contract described in Subsection (1) shall include a prominently displayed notice in 12-point boldface type that states "WE REPRESENT THE INSURED ONLY."

(b) The commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, may require additional prominently displayed notice requirements in the contract as the commissioner considers necessary.

(4) A public adjuster shall keep at the public adjuster's principal place of business a copy of each contract entered into in this state for the current year plus three years, and each contract shall be available at all times for inspection, without notice, by the commissioner or the commissioner's authorized representative.

(5) A public adjuster may not enter into a contract with an insured and collect compensation as provided in the contract without actually performing the services customarily provided by a licensed public adjuster for the insured.

Section 51. Section **31A-26-402** is enacted to read:

31A-26-402. Compensation.

(1) Except as provided by Subsection (2), a public adjuster may receive compensation for service provided under this chapter consisting of an hourly fee, a flat rate, a percentage of the total amount paid by an insurer to resolve a claim, or another method of compensation.

(2) (a) A public adjuster may not receive a compensation consisting of a percentage of the total amount paid by an insurer to resolve a claim on a claim on which the insurer, not later than 72 hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy.

(b) A public adjuster is entitled to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim that is subject to this Subsection (2) and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

(3) Except for the payment of compensation by the insured, a person paying proceeds of a policy of insurance or making a payment affecting an insured's rights under a policy of insurance shall:

(a) include the insured as a payee on the payment draft or check; and

(b) require the written signature and endorsement of the insured on the payment draft or check.

(4) A public adjuster may not accept any payment that violates this section

notwithstanding whether the insured gives authorization to the public adjuster. A public adjuster may not sign and endorse any payment draft or check on behalf of an insured.

Section 52. Section **31A-26-403** is enacted to read:

31A-26-403. Rulemaking.

The commissioner may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(1) addressing the forms required by this part;

(2) providing for notice requirements in contracts; and

(3) establishing the scope of a contract a public adjuster enters into with an insured that the public adjuster represents.

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~~] plans.

(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;

(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~~] plans 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~~] plans; and

(B) prescribe the manner in which case characteristics may be used by carriers who offer health benefit plans to individuals.

(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~~] plan is a health benefit [~~product~~] plan 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) 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) 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 record under Title 63G, Chapter 2, Government Records Access and Management Act.

Section 54. Section **31A-30-106.1** is amended to read:

31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for small employer health benefit plans under this chapter are

subject to this section.

(2) (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) 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 an employer group 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 when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

(3) 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:

(a) 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;

(b) 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 small employer carrier's rate manual for the class of business, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d); and

(c) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined for the class of business from the small employer carrier's rate manual.

(4) (a) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.

(b) Rating adjustments and factors, including case characteristics, shall be applied uniformly and consistently to the rates charged for all employees and dependents of the small employer.

(c) Rating factors shall produce premiums for identical groups that:

(i) differ only by the amounts attributable to plan design; and

(ii) do not reflect differences due to the nature of the groups assumed to select particular health benefit [~~products~~] plans.

(d) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(5) 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.

(6) The small employer carrier may not use case characteristics other than the following:

(a) age of the employee, in accordance with Subsection (7);

(b) geographic area;

(c) family composition in accordance with Subsection (9);

(d) for plans renewed or effective on or after July 1, 2011, gender of the employee and spouse;

(e) for an individual age 65 and older, whether the employer policy is primary or secondary to Medicare; and

(f) a wellness program, in accordance with Subsection (12).

(7) Age limited to:

(a) the following age bands:

(i) less than 20;

(ii) 20-24;

(iii) 25-29;

(iv) 30-34;

(v) 35-39;

(vi) 40-44;

(vii) 45-49;

(viii) 50-54;

(ix) 55-59;

(x) 60-64; and

(xi) 65 and above; and

(b) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection (9)(b):

(i) as developed by the commissioner by administrative rule; and

(ii) not to exceed an overall ratio as provided in Subsection (8).

(8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:

(i) 5:1 for plans renewed or effective before January 1, 2012; and

(ii) 6:1 for plans renewed or effective on or after January 1, 2012; and

(b) the age slope ratios for each age band may not overlap.

(9) Except as provided in Subsection 31A-30-207(2), family composition is limited to:

(a) an overall ratio of:

(i) 5:1 or less for plans renewed or effective before January 1, 2012; and

(ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and

(b) a tier rating structure that includes:

(i) four tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a child or children; and

(D) a family, consisting of an employee plus spouse, and a child or children;

(ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus one child;

(D) employee plus two or more children; and

(E) employee plus spouse plus one or more children; or

(iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus one child;

(D) employee plus two or more children;

(E) employee plus spouse plus one child; and

(F) employee plus spouse plus two or more children.

(10) If a health benefit plan is a health benefit plan into which the small employer carrier is no longer enrolling new covered insureds, the small employer 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~~] plan into which the small employer carrier is actively enrolling new covered insureds.

(11) (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.

(12) Notwithstanding Subsection (4)(b), a small employer carrier may:

(a) offer a wellness program to a small employer group if:

(i) the premium discount to the employer for the wellness program does not exceed

20% of the premium for the small employer group; and

(ii) the carrier offers the wellness program discount uniformly across all small employer groups;

(b) offer a premium discount as part of a wellness program to individual employees in a small employer group:

(i) to the extent allowed by federal law; and

(ii) if the employee discount based on the wellness program is offered uniformly across all small employer groups; and

(c) offer a combination of premium discounts for the employer and the employee, based on a wellness program, if:

(i) the employer discount complies with Subsection (12)(a); and

(ii) the employee discount complies with Subsection (12)(b).

(13) (a) [~~Each~~] A small employer carrier shall maintain at the small employer 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 small employer 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 small employer carrier shall file with the commissioner on or before April 1 of each year, in a form and manner and containing information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the small employer carrier is in compliance with this chapter; and

(B) the rating methods of the small employer carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (13)(b)(i) shall be retained by the small employer carrier at the small employer carrier's principal place of business.

(c) A small employer carrier shall make the information and documentation described in this Subsection (13) available to the commissioner upon request.

(14) (a) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(i) implement this chapter; and

(ii) assure that rating practices used by small employer carriers under this section and carriers for individual plans under Section 31A-30-106 are consistent with the purposes of this chapter.

(b) The rules may:

(i) assure that differences in rates charged for health benefit plans by carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups or individuals assumed to select particular health benefit plans; and

(ii) prescribe the manner in which case characteristics may be used by small employer and individual carriers.

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

Section 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 there is no longer any enrollee under the group health plan who lives, resides, or works in:

(i) the service area of the covered carrier; or

(ii) the area for which the covered carrier is authorized to do business; 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~~] plan 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~~] plans currently being offered by the small employer carrier in the market; and

(D) in exercising the option to discontinue that [~~product~~] health benefit plan 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-30-107.1** is amended to read:

31A-30-107.1. Individual discontinuance and nonrenewal.

(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all individuals or dependents; and

(ii) at the option of the individual.

(b) Subsection (1)(a) applies regardless of:

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

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

(a) for a network plan, if:

(i) the individual no longer lives, resides, or works in:

(A) the service area of the covered carrier; or

(B) the area for which the covered carrier is authorized to do business; and

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

(b) for coverage made available through an association, if:

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

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

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

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

(b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the individual:

(i) performs an act or practice that constitutes fraud in connection with the coverage; 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 health benefit [~~product~~] plan delivered or issued for delivery in this state; and

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

(I) to each individual provided coverage; 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 individuals;

(C) offers to each covered individual on a guaranteed issue basis the option to purchase all other individual health benefit [~~products~~] plans currently being offered by the covered carrier for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or dependent of a covered individual who may become eligible for coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's health benefit plans in the individual market; and

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

(I) to each covered individual; 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 individuals;

(C) discontinues and nonrenews all health benefit plans the covered carrier issues or delivers for issuance in the individual market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or a dependent of a covered individual who may become eligible for coverage.

Section 57. Section **31A-35-103** is amended to read:

31A-35-103. Exemption from other provisions of this title.

Bail bond agencies are exempted from:

(1) Chapter 3, Department Funding, Fees, and Taxes, except Section 31A-3-103;

(2) Chapter 4, Insurers in General, except Sections 31A-4-102, 31A-4-103, 31A-4-104, and 31A-4-107;

(3) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except Section 31A-5-103;

(4) Chapter 6a, Service Contracts;

(5) Chapter 6b, Guaranteed Asset Protection Waiver Act;

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

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

(8) Chapter 8a, Health Discount Program Consumer Protection Act;

(9) Chapter 9, Insurance Fraternals;

(10) Chapter 10, Annuities;

(11) Chapter 11, Motor Clubs;

(12) Chapter 12, State Risk Management Fund;

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

(14) Chapter 14, Foreign Insurers;

(15) Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups;

(16) Chapter 16, Insurance Holding Companies;

(17) Chapter 17, Determination of Financial Condition;

(18) Chapter 18, Investments;

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

(20) Chapter 20, Underwriting Restrictions;

(21) Chapter 23b, Navigator License Act;

(22) Chapter 25, Third Party Administrators;

(23) Chapter 26, Insurance Adjusters;

(24) Chapter 27, Delinquency Administrative Action Provisions;

(25) Chapter 27a, Insurer Receivership Act;

(26) Chapter 28, Guaranty Associations;

(27) Chapter 30, Individual, Small Employer, and Group Health Insurance Act;

(28) Chapter 31, Insurance Fraud Act;

(29) Chapter 32a, Medical Care Savings Account Act;

(30) Chapter 33, Workers' Compensation Fund;

[~~(31) Chapter 34, Voluntary Health Insurance Purchasing Alliance Act;~~]

[~~(32)~~] (31) Chapter 36, Life Settlements Act;

[~~(33)~~] (32) Chapter 37, Captive Insurance Companies Act;

[~~(34)~~] (33) Chapter 37a, Special Purpose Financial Captive Insurance Company Act;

[~~(35)~~] (34) Chapter 38, Federal Health Care Tax Credit Program Act;

[~~(36)~~] (35) Chapter 39, Interstate Insurance Product Regulation Compact;

[~~(37)~~] (36) Chapter 40, Professional Employer Organization Licensing Act;

[~~(38)~~] (37) Chapter 41, Title Insurance Recovery, Education, and Research Fund Act;

[~~(39)~~] (38) Chapter 42, Defined Contribution Risk Adjuster Act; and

[~~(40)~~] (39) Chapter 43, Small Employer Stop-Loss Insurance Act.

Section 58. Section **31A-37-102** is amended to read:

31A-37-102. Definitions.

As used in this chapter:

(1) (a) "Affiliated company" means a business entity that because of common ownership, control, operation, or management is in the same corporate or limited liability company system as:

[~~(a)~~] (i) a parent;

[~~(b)~~] (ii) an industrial insured; or

[~~(c)~~] (iii) a member organization.

(b) Notwithstanding Subsection (1)(a), the commissioner may issue an order finding that a business entity is not an affiliated company.

(2) "Alien captive insurance company" means an insurer:

(a) formed to write insurance business for a parent or affiliate of the insurer; and

(b) licensed pursuant to the laws of an alien or foreign jurisdiction that imposes statutory or regulatory standards:

(i) on a business entity transacting the business of insurance in the alien or foreign jurisdiction; and

(ii) in a form acceptable to the commissioner.

(3) "Association" means a legal association of two or more persons that has been in continuous existence for at least one year if:

(a) the association or its member organizations:

(i) own, control, or hold with power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer; or

(ii) have complete voting control over an association captive insurance company incorporated as a mutual insurer;

(b) the association's member organizations collectively constitute all of the subscribers

of an association captive insurance company formed as a reciprocal insurer; or

(c) the association or its member organizations have complete voting control over an association captive insurance company formed as a limited liability company.

(4) "Association captive insurance company" means a business entity that insures risks of:

(a) a member organization of the association;

(b) an affiliate of a member organization of the association; and

(c) the association.

(5) "Branch business" means an insurance business transacted by a branch captive insurance company in this state.

(6) "Branch captive insurance company" means an alien captive insurance company that has a certificate of authority from the commissioner to transact the business of insurance in this state through a captive insurance company that is domiciled outside of this state.

(7) "Branch operation" means a business operation of a branch captive insurance company in this state.

(8) "Captive insurance company" means any of the following formed or holding a certificate of authority under this chapter:

(a) a branch captive insurance company;

(b) a pure captive insurance company;

(c) an association captive insurance company;

(d) a sponsored captive insurance company;

(e) an industrial insured captive insurance company, including an industrial insured captive insurance company formed as a risk retention group captive in this state pursuant to the provisions of the Federal Liability Risk Retention Act of 1986;

(f) a special purpose captive insurance company; or

(g) a special purpose financial captive insurance company.

(9) "Commissioner" means Utah's Insurance Commissioner or the commissioner's

designee.

(10) "Common ownership and control" means that two or more captive insurance companies are owned or controlled by the same person or group of persons as follows:

(a) in the case of a captive insurance company that is a stock corporation, the direct or indirect ownership of 80% or more of the outstanding voting stock of the stock corporation;

(b) in the case of a captive insurance company that is a mutual corporation, the direct or indirect ownership of 80% or more of the surplus and the voting power of the mutual corporation;

(c) in the case of a captive insurance company that is a limited liability company, the direct or indirect ownership by the same member or members of 80% or more of the membership interests in the limited liability company; or

(d) in the case of a sponsored captive insurance company, a protected cell is a separate captive insurance company owned and controlled by the protected cell's participant, only if:

(i) the participant is the only participant with respect to the protected cell; and

(ii) the participant is the sponsor or is affiliated with the sponsor of the sponsored captive insurance company through common ownership and control.

(11) "Consolidated debt to total capital ratio" means the ratio of Subsection (11)(a) to (b).

(a) This Subsection (11)(a) is an amount equal to the sum of all debts and hybrid capital instruments including:

(i) all borrowings from depository institutions;

(ii) all senior debt;

(iii) all subordinated debts;

(iv) all trust preferred shares; and

(v) all other hybrid capital instruments that are not included in the determination of consolidated GAAP net worth issued and outstanding.

(b) This Subsection (11)(b) is an amount equal to the sum of:

(i) total capital consisting of all debts and hybrid capital instruments as described in Subsection (11)(a); and

(ii) shareholders' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission.

(12) "Consolidated GAAP net worth" means the consolidated shareholders' or members' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission.

(13) "Controlled unaffiliated business" means a business entity:

(a) (i) in the case of a pure captive insurance company, that is not in the corporate or limited liability company system of a parent or the parent's affiliate; or

(ii) in the case of an industrial insured captive insurance company, that is not in the corporate or limited liability company system of an industrial insured or an affiliated company of the industrial insured;

(b) (i) in the case of a pure captive insurance company, that has a contractual relationship with a parent or affiliate; or

(ii) in the case of an industrial insured captive insurance company, that has a contractual relationship with an industrial insured or an affiliated company of the industrial insured; and

(c) whose risks that are or will be insured by a pure captive insurance company, an industrial insured captive insurance company, or both are managed [~~by one of the following~~] in accordance with Subsection 31A-37-106(1)(j) by:

(i) (A) a pure captive insurance company; or

[~~(ii)~~] (B) an industrial insured captive insurance company[~~.~~]; or

(ii) a parent or affiliate of:

(A) a pure captive insurance company; or

(B) an industrial insured captive insurance company.

(14) "Department" means the Insurance Department.

(15) "Industrial insured" means an insured:

(a) that produces insurance:

(i) by the services of a full-time employee acting as a risk manager or insurance manager; or

(ii) using the services of a regularly and continuously qualified insurance consultant;

(b) whose aggregate annual premiums for insurance on all risks total at least $25,000; and

(c) that has at least 25 full-time employees.

(16) "Industrial insured captive insurance company" means a business entity that:

(a) insures risks of the industrial insureds that comprise the industrial insured group; and

(b) may insure the risks of:

(i) an affiliated company of an industrial insured; or

(ii) a controlled unaffiliated business of:

(A) an industrial insured; or

(B) an affiliated company of an industrial insured.

(17) "Industrial insured group" means:

(a) a group of industrial insureds that collectively:

(i) own, control, or hold with power to vote all of the outstanding voting securities of an industrial insured captive insurance company incorporated or organized as a limited liability company as a stock insurer; or

(ii) have complete voting control over an industrial insured captive insurance company incorporated or organized as a limited liability company as a mutual insurer;

(b) a group that is:

(i) created under the Product Liability Risk Retention Act of 1981, 15 U.S.C. Sec. 3901 et seq., as amended, as a corporation or other limited liability association; and

(ii) taxable under this title as a:

(A) stock corporation; or

(B) mutual insurer; or

(c) a group that has complete voting control over an industrial captive insurance company formed as a limited liability company.

(18) "Member organization" means a person that belongs to an association.

(19) "Parent" means a person that directly or indirectly owns, controls, or holds with power to vote more than 50% of:

(a) the outstanding voting securities of a pure captive insurance company; or

(b) the pure captive insurance company, if the pure captive insurance company is formed as a limited liability company.

(20) "Participant" means an entity that is insured by a sponsored captive insurance company:

(a) if the losses of the participant are limited through a participant contract to the assets of a protected cell; and

(b)(i) the entity is permitted to be a participant under Section 31A-37-403; or

(ii) the entity is an affiliate of an entity permitted to be a participant under Section 31A-37-403.

(21) "Participant contract" means a contract by which a sponsored captive insurance company:

(a) insures the risks of a participant; and

(b) limits the losses of the participant to the assets of a protected cell.

(22) "Protected cell" means a separate account established and maintained by a sponsored captive insurance company for one participant.

(23) "Pure captive insurance company" means a business entity that insures risks of a parent or affiliate of the business entity.

(24) "Special purpose financial captive insurance company" is as defined in Section 31A-37a-102.

(25) "Sponsor" means an entity that:

(a) meets the requirements of Section 31A-37-402; and

(b) is approved by the commissioner to:

(i) provide all or part of the capital and surplus required by applicable law in an amount of not less than $350,000, which amount the commissioner may increase by order if the commissioner considers it necessary; and

(ii) organize and operate a sponsored captive insurance company.

(26) "Sponsored captive insurance company" means a captive insurance company:

(a) in which the minimum capital and surplus required by applicable law is provided by one or more sponsors;

(b) that is formed or holding a certificate of authority under this chapter;

(c) that insures the risks of a separate participant through the contract; and

(d) that segregates each participant's liability through one or more protected cells.

(27) "Treasury rates" means the United States Treasury strip asked yield as published in the Wall Street Journal as of a balance sheet date.

Section 59. Section **31A-37-106** is amended to read:

31A-37-106. Authority to make rules -- Authority to issue orders.

(1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may adopt rules to:

(a) determine circumstances under which a branch captive insurance company is not required to be a pure captive insurance company;

(b) require a statement, document, or information that a captive insurance company shall provide to the commissioner to obtain a certificate of authority;

(c) determine a factor a captive insurance company shall provide evidence of under Subsection 31A-37-202(4)[~~(c)~~](b);

(d) prescribe one or more capital requirements for a captive insurance company in addition to those required under Section 31A-37-204 based on the type, volume, and nature of

insurance business transacted by the captive insurance company;

(e) waive or modify a requirement for public notice and hearing for the following by a captive insurance company:

(i) merger;

(ii) consolidation;

(iii) conversion;

(iv) mutualization;

(v) redomestication; or

(vi) acquisition;

(f) approve the use of one or more reliable methods of valuation and rating for:

(i) an association captive insurance company;

(ii) a sponsored captive insurance company; or

(iii) an industrial insured group;

(g) prohibit or limit an investment that threatens the solvency or liquidity of:

(i) a pure captive insurance company; or

(ii) an industrial insured captive insurance company;

(h) determine the financial reports a sponsored captive insurance company shall annually file with the commissioner;

(i) prescribe the required forms and reports under Section 31A-37-501; and

(j) establish one or more standards to ensure that:

(i) one of the following is able to exercise control of the risk management function of a controlled unaffiliated business to be insured by a pure captive insurance company:

(A) a parent; or

(B) an affiliated company of a parent; or

(ii) one of the following is able to exercise control of the risk management function of a controlled unaffiliated business to be insured by an industrial insured captive insurance company:

(A) an industrial insured; or

(B) an affiliated company of the industrial insured.

(2) Notwithstanding Subsection (1)(j), until the commissioner adopts the rules authorized under Subsection (1)(j), the commissioner may by temporary order grant authority to insure risks to:

(a) a pure captive insurance company; or

(b) an industrial insured captive insurance company.

(3) The commissioner may issue prohibitory, mandatory, and other orders relating to a captive insurance company as necessary to enable the commissioner to secure compliance with this chapter.

Section 60. Section **31A-37-202** is amended to read:

31A-37-202. Permissive areas of insurance.

(1) (a) Except as provided in Subsection (1)(b), when permitted by its articles of incorporation, certificate of organization, or charter, a captive insurance company may apply to the commissioner for a certificate of authority to do all insurance authorized by this title except workers' compensation insurance.

(b) Notwithstanding Subsection (1)(a):

(i) a pure captive insurance company may not insure a risk other than a risk of:

(A) [~~its~~] the pure captive insurance company's parent or affiliate;

(B) a controlled unaffiliated business; or

(C) a combination of Subsections (1)(b)(i)(A) and (B);

(ii) an association captive insurance company may not insure a risk other than a risk of:

(A) an affiliate;

(B) a member organization of its association; and

(C) an affiliate of a member organization of its association;

(iii) an industrial insured captive insurance company may not insure a risk other than a risk of:

(A) an industrial insured that is part of the industrial insured group;

(B) an affiliate of an industrial insured that is part of the industrial insured group; and

(C) a controlled unaffiliated business of:

(I) an industrial insured that is part of the industrial insured group; or

(II) an affiliate of an industrial insured that is part of the industrial insured group;

(iv) a special purpose captive insurance company may only insure a risk of its parent;

(v) a captive insurance company may not provide:

(A) personal motor vehicle insurance coverage;

(B) homeowner's insurance coverage; or

(C) a component of a coverage described in this Subsection (1)(b)(v); and

(vi) a captive insurance company may not accept or cede reinsurance except as provided in Section 31A-37-303.

(c) Notwithstanding Subsection (1)(b)(iv), for a risk approved by the commissioner a special purpose captive insurance company may provide:

(i) insurance;

(ii) reinsurance; or

(iii) both insurance and reinsurance.

(2) To conduct insurance business in this state a captive insurance company shall:

(a) obtain from the commissioner a certificate of authority authorizing it to conduct insurance business in this state;

(b) hold at least once each year in this state:

(i) a board of directors meeting; or

[~~(ii) in the case of a reciprocal insurer, a subscriber's advisory committee meeting; or~~]

[~~(iii)~~] (ii) in the case of a limited liability company, a meeting of the managers;

(c) maintain in this state:

(i) the principal place of business of the captive insurance company; or

(ii) in the case of a branch captive insurance company, the principal place of business

for the branch operations of the branch captive insurance company; and

(d) except as provided in Subsection (3), appoint a resident registered agent to accept service of process and to otherwise act on behalf of the captive insurance company in this state.

(3) Notwithstanding Subsection (2)(d), in the case of a captive insurance company formed as a corporation [~~or a reciprocal insurer~~], if the registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the commissioner is the agent of the captive insurance company upon whom process, notice, or demand may be served.

(4) (a) Before receiving a certificate of authority, a captive insurance company:

(i) formed as a corporation shall file with the commissioner:

(A) a certified copy of:

(I) articles of incorporation or the charter of the corporation; and

(II) bylaws of the corporation;

(B) a statement under oath of the president and secretary of the corporation showing the financial condition of the corporation; and

(C) any other statement or document required by the commissioner under Section 31A-37-106; and

[~~(ii) formed as a reciprocal shall:~~]

[~~(A) file with the commissioner:~~]

[~~(I) a certified copy of the power of attorney of the attorney-in-fact of the reciprocal;~~]

[~~(II) a certified copy of the subscribers' agreement of the reciprocal;~~]

[~~(III) a statement under oath of the attorney-in-fact of the reciprocal showing the financial condition of the reciprocal; and~~]

[~~(IV) any other statement or document required by the commissioner under Section 31A-37-106; and~~]

[~~(B) submit to the commissioner for approval a description of the:~~]

[~~(I) coverages;~~]

[~~(II) deductibles;~~]

[~~(III) coverage limits;~~]

[~~(IV) rates; and~~]

[~~(V) any other information the commissioner requires under Section 31A-37-106; and~~]

[~~(iii)~~] (ii) formed as a limited liability company shall file with the commissioner:

(A) a certified copy of the certificate of organization and the operating agreement of the organization;

(B) a statement under oath of the president and secretary of the organization showing the financial condition of the organization;

(C) evidence that the limited liability company is manager-managed; and

(D) any other statement or document required by the commissioner under Section 31A-37-106.

[~~(b) (i) If there is a subsequent material change in an item in the description required under Subsection (4)(a)(ii)(B) for a reciprocal captive insurance company, the reciprocal captive insurance company shall submit to the commissioner for approval an appropriate revision to the description required under Subsection (4)(a)(ii)(B).~~]

[~~(ii) A reciprocal captive insurance company that is required to submit a revision under Subsection (4)(b)(i) may not offer any additional types of insurance until the commissioner approves a revision of the description.~~]

[~~(iii) A reciprocal captive insurance company shall inform the commissioner of a material change in a rate within 30 days of the adoption of the change.~~]

[~~(c)~~] (b) In addition to the information required by Subsection (4)(a), an applicant captive insurance company shall file with the commissioner evidence of:

(i) the amount and liquidity of the assets of the applicant captive insurance company relative to the risks to be assumed by the applicant captive insurance company;

(ii) the adequacy of the expertise, experience, and character of the person who will manage the applicant captive insurance company;

(iii) the overall soundness of the plan of operation of the applicant captive insurance company;

(iv) the adequacy of the loss prevention programs for the following of the applicant captive insurance company:

(A) a parent;

(B) a member organization; or

(C) an industrial insured; and

(v) any other factor the commissioner:

(A) adopts by rule under Section 31A-37-106; and

(B) considers relevant in ascertaining whether the applicant captive insurance company will be able to meet the policy obligations of the applicant captive insurance company.

[~~(d)~~] (c) In addition to the information required by Subsections (4)(a)[~~,~~] and (b)[~~, and (c),~~] an applicant sponsored captive insurance company shall file with the commissioner:

(i) a business plan at the level of detail required by the commissioner under Section 31A-37-106 demonstrating:

(A) the manner in which the applicant sponsored captive insurance company will account for the losses and expenses of each protected cell; and

(B) the manner in which the applicant sponsored captive insurance company will report to the commissioner the financial history, including losses and expenses, of each protected cell;

(ii) a statement acknowledging that the applicant sponsored captive insurance company will make all financial records of the applicant sponsored captive insurance company, including records pertaining to a protected cell, available for inspection or examination by the commissioner;

(iii) a contract or sample contract between the applicant sponsored captive insurance company and a participant; and

(iv) evidence that expenses will be allocated to each protected cell in an equitable manner.

(5) (a) Information submitted pursuant to Subsection (4) is classified as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

(b) Notwithstanding Title 63G, Chapter 2, Government Records Access and Management Act, the commissioner may disclose information submitted pursuant to Subsection (4) to a public official having jurisdiction over the regulation of insurance in another state if:

(i) the public official receiving the information agrees in writing to maintain the confidentiality of the information; and

(ii) the laws of the state in which the public official serves require the information to be confidential.

(c) This Subsection (5) does not apply to information provided by an industrial insured captive insurance company insuring the risks of an industrial insured group.

(6) (a) A captive insurance company shall pay to the department the following nonrefundable fees established by the department under Sections 31A-3-103, 31A-3-304, and 63J-1-504:

(i) a fee for examining, investigating, and processing, by a department employee, of an application for a certificate of authority made by a captive insurance company;

(ii) a fee for obtaining a certificate of authority for the year the captive insurance company is issued a certificate of authority by the department; and

(iii) a certificate of authority renewal fee.

(b) The commissioner may:

(i) assign a department employee or retain legal, financial, and examination services from outside the department to perform the services described in:

(A) Subsection (6)(a); and

(B) Section 31A-37-502; and

(ii) charge the reasonable cost of services described in Subsection (6)(b)(i) to the applicant captive insurance company.

(7) If the commissioner is satisfied that the documents and statements filed by the applicant captive insurance company comply with this chapter, the commissioner may grant a certificate of authority authorizing the company to do insurance business in this state.

(8) A certificate of authority granted under this section expires annually and shall be renewed by July 1 of each year.

Section 61. Section **31A-37-204** is amended to read:

31A-37-204. Paid-in capital -- Other capital.

(1) (a) The commissioner may not issue a certificate of authority to a company described in Subsection (1)(c) unless the company possesses and thereafter maintains unimpaired paid-in capital and unimpaired paid-in surplus of:

(i) in the case of a pure captive insurance company, not less than $250,000;

(ii) in the case of an association captive insurance company [~~incorporated as a stock insurer~~], not less than $750,000;

(iii) in the case of an industrial insured captive insurance company incorporated as a stock insurer, not less than $700,000;

(iv) in the case of a sponsored captive insurance company, not less than $1,000,000, of which a minimum of $350,000 is provided by the sponsor; or

(v) in the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro-formas, including the nature of the risks to be insured.

(b) The paid-in capital and surplus required under this Subsection (1) may be in the form of:

(i) (A) cash; or

(B) cash equivalent;

(ii) an irrevocable letter of credit:

(A) issued by:

(I) a bank chartered by this state; or

(II) a member bank of the Federal Reserve System; and

(B) approved by the commissioner; [~~or~~]

(iii) marketable securities as determined by [~~Subsections 31A-18-105(1) and (6).~~] Subsection (5); or

(iv) some other thing of value approved by the commissioner, for a period not to exceed 45 days, to facilitate the formation of a captive insurance company in this state pursuant to an approved plan of liquidation and reorganization of another captive insurance company or alien captive insurance company in another jurisdiction.

(c) This Subsection (1) applies to:

(i) a pure captive insurance company;

(ii) a sponsored captive insurance company;

(iii) a special purpose captive insurance company;

(iv) an association captive insurance company [~~incorporated as a stock insurer~~]; or

(v) an industrial insured captive insurance company [~~incorporated as a stock insurer~~].

(2) (a) The commissioner may, under Section 31A-37-106, prescribe additional capital based on the type, volume, and nature of insurance business transacted.

(b) The capital prescribed by the commissioner under this Subsection (2) may be in the form of:

(i) cash;

(ii) an irrevocable letter of credit issued by:

(A) a bank chartered by this state; or

(B) a member bank of the Federal Reserve System; or

(iii) marketable securities as determined by [~~Subsections 31A-18-105(1) and (6)~~] Subsection (5).

(3) (a) Except as provided in Subsection (3)(c), a branch captive insurance company, as security for the payment of liabilities attributable to branch operations, shall, through its branch operations, establish and maintain a trust fund:

(i) funded by an irrevocable letter of credit or other acceptable asset; and

(ii) in the United States for the benefit of:

(A) United States policyholders; and

(B) United States ceding insurers under:

(I) insurance policies issued; or

(II) reinsurance contracts issued or assumed.

(b) The amount of the security required under this Subsection (3) shall be no less than:

(i) the capital and surplus required by this chapter; and

(ii) the reserves on the insurance policies or reinsurance contracts, including:

(A) reserves for losses;

(B) allocated loss adjustment expenses;

(C) incurred but not reported losses; and

(D) unearned premiums with regard to business written through branch operations.

(c) Notwithstanding the other provisions of this Subsection (3)[~~,~~]:

(i) the commissioner may permit a branch captive insurance company that is required to post security for loss reserves on branch business by its reinsurer to reduce the funds in the trust account required by this section by the same amount as the security posted if the security remains posted with the reinsurer[~~.~~]; and

(ii) a branch captive insurance company that is the result of the licensure of an alien captive insurance company that is not formed in an alien jurisdiction is not subject to the requirements of this Subsection (3).

(4) (a) A captive insurance company may not pay the following without the prior approval of the commissioner:

(i) a dividend out of capital or surplus in excess of the limits under Section 16-10a-640; or

(ii) a distribution with respect to capital or surplus in excess of the limits under Section 16-10a-640.

(b) The commissioner shall condition approval of an ongoing plan for the payment of dividends or other distributions on the retention, at the time of each payment, of capital or surplus in excess of:

(i) amounts specified by the commissioner under Section 31A-37-106; or

(ii) determined in accordance with formulas approved by the commissioner under Section 31A-37-106.

[~~(5) Notwithstanding Subsection (1), a captive insurance company organized as a reciprocal insurer under this chapter may not be issued a certificate of authority unless the captive insurance company possesses and maintains unimpaired paid-in surplus of $1,000,000.~~]

[~~(6) (a) The commissioner may prescribe additional unimpaired paid-in surplus based upon the type, volume, and nature of the insurance business transacted.~~]

[~~(b) The unimpaired paid-in surplus required under this Subsection (6) may be in the form of an irrevocable letter of credit issued by:~~]

[~~(i) a bank chartered by this state; or~~]

[~~(ii) a member bank of the Federal Reserve System.~~]

(5) For purposes of this section, marketable securities means:

(a) a bond or other evidence of indebtedness of a governmental unit in the United States or Canada or any instrumentality of the United States or Canada; or

(b) securities:

(i) traded on one or more of the following exchanges in the United States:

(A) New York;

(B) American; or

(C) NASDAQ;

(ii) when no particular security, or a substantially related security, applied toward the required minimum capital and surplus requirement of Subsection (1) represents more than 50% of the minimum capital and surplus requirement; and

(iii) when no group of up to four particular securities, consolidating substantially

related securities, applied toward the required minimum capital and surplus requirement of Subsection (1) represents more than 90% of the minimum capital and surplus requirement.

(6) Notwithstanding Subsection (5), to protect the solvency and liquidity of a captive insurance company, the commissioner may reject the application of specific assets or amounts of specific assets to satisfying the requirement of Subsection (1).

Section 62. Section **31A-37-301** is amended to read:

31A-37-301. Formation.

(1) A pure captive insurance company or a sponsored captive insurance company formed as a stock insurer shall be incorporated as a stock insurer with the capital of the pure captive insurance company or sponsored captive insurance company:

(a) divided into shares; and

(b) held by the stockholders of the pure captive insurance company or sponsored captive insurance company.

(2) A pure captive insurance company or a sponsored captive insurance company formed as a limited liability company shall be organized as a members' interest insurer with the capital of the pure captive insurance company or sponsored captive insurance company:

(a) divided into interests; and

(b) held by the members of the pure captive insurance company or sponsored captive insurance company.

(3) An association captive insurance company or an industrial insured captive insurance company may be:

(a) incorporated as a stock insurer with the capital of the association captive insurance company or industrial insured captive insurance company:

(i) divided into shares; and

(ii) held by the stockholders of the association captive insurance company or industrial insured captive insurance company;

(b) incorporated as a mutual insurer without capital stock, with a governing body

elected by the member organizations of the association captive insurance company or industrial insured captive insurance company; or

[~~(c) organized as a reciprocal.~~]

(c) organized as a limited liability company with the capital of the association captive insurance company or industrial insured captive insurance company:

(i) divided into interests; and

(ii) held by the members of the association captive insurance company or industrial insured captive insurance company.

(4) A captive insurance company formed as a corporation may not have fewer than three incorporators of whom one shall be a resident of this state.

(5) A captive insurance company formed as a limited liability company may not have fewer than three organizers of whom one shall be a resident of this state.

(6) (a) Before a captive insurance company formed as a corporation files the corporation's articles of incorporation with the Division of Corporations and Commercial Code, the incorporators shall obtain from the commissioner a certificate finding that the establishment and maintenance of the proposed corporation will promote the general good of the state.

(b) In considering a request for a certificate under Subsection (6)(a), the commissioner shall consider:

(i) the character, reputation, financial standing, and purposes of the incorporators;

(ii) the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors;

(iii) any information in:

(A) the application for a certificate of authority; or

(B) the department's files; and

(iv) other aspects that the commissioner considers advisable.

(7) (a) Before a captive insurance company formed as a limited liability company files

the limited liability company's certificate of organization with the Division of Corporations and Commercial Code, the limited liability company shall obtain from the commissioner a certificate finding that the establishment and maintenance of the proposed limited liability company will promote the general good of the state.

(b) In considering a request for a certificate under Subsection (7)(a), the commissioner shall consider:

(i) the character, reputation, financial standing, and purposes of the organizers;

(ii) the character, reputation, financial responsibility, insurance experience, and business qualifications of the managers;

(iii) any information in:

(A) the application for a certificate of authority; or

(B) the department's files; and

(iv) other aspects that the commissioner considers advisable.

(8) (a) A captive insurance company formed as a corporation shall file with the Division of Corporations and Commercial Code:

(i) the captive insurance company's articles of incorporation;

(ii) the certificate issued pursuant to Subsection (6); and

(iii) the fees required by the Division of Corporations and Commercial Code.

(b) The Division of Corporations and Commercial Code shall file both the articles of incorporation and the certificate described in Subsection (6) for a captive insurance company that complies with this section.

(9) (a) A captive insurance company formed as a limited liability company shall file with the Division of Corporations and Commercial Code:

(i) the captive insurance company's certificate of organization;

(ii) the certificate issued pursuant to Subsection (7); and

(iii) the fees required by the Division of Corporations and Commercial Code.

(b) The Division of Corporations and Commercial Code shall file both the certificate

of organization and the certificate described in Subsection (7) for a captive insurance company that complies with this section.

(10) (a) The organizers of a captive insurance company formed as a reciprocal insurer shall obtain from the commissioner a certificate finding that the establishment and maintenance of the proposed association will promote the general good of the state.

(b) In considering a request for a certificate under Subsection (10)(a), the commissioner shall consider:

(i) the character, reputation, financial standing, and purposes of the incorporators;

(ii) the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors;

(iii) any information in:

(A) the application for a certificate of authority; or

(B) the department's files; and

(iv) other aspects that the commissioner considers advisable.

(11) (a) An alien captive insurance company that has received a certificate of authority to act as a branch captive insurance company shall obtain from the commissioner a certificate finding that:

(i) the home [~~state~~] jurisdiction of the alien captive insurance company imposes statutory or regulatory standards in a form acceptable to the commissioner on companies transacting the business of insurance in that state; and

(ii) after considering the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors of the alien captive insurance company, and other relevant information, the establishment and maintenance of the branch operations will promote the general good of the state.

(b) After the commissioner issues a certificate under Subsection (11)(a) to an alien captive insurance company, the alien captive insurance company may register to do business in this state.

(12) At least one of the members of the board of directors of a captive insurance company formed as a corporation shall be a resident of this state.

(13) At least one of the managers of a limited liability company shall be a resident of this state.

[~~(14) At least one of the members of the subscribers' advisory committee of a captive insurance company formed as a reciprocal insurer shall be a resident of this state.~~]

[~~(15)~~] (14) (a) A captive insurance company formed as a corporation under this chapter has the privileges and is subject to the provisions of the general corporation law as well as the applicable provisions contained in this chapter.

(b) If a conflict exists between a provision of the general corporation law and a provision of this chapter, this chapter shall control.

(c) Except as provided in Subsection [~~(15)~~] (14)(d), the provisions of this title pertaining to a merger, consolidation, conversion, mutualization, and redomestication apply in determining the procedures to be followed by a captive insurance company in carrying out any of the transactions described in those provisions.

(d) Notwithstanding Subsection [~~(15)~~] (14)(c), the commissioner may waive or modify the requirements for public notice and hearing in accordance with rules adopted under Section 31A-37-106.

(e) If a notice of public hearing is required, but no one requests a hearing, the commissioner may cancel the public hearing.

[~~(16)~~] (15) (a) A captive insurance company formed as a limited liability company under this chapter has the privileges and is subject to [~~Title 48, Chapter 2c, Utah Revised Limited Liability Company Act, or~~] Title 48, Chapter 3a, Utah Revised Uniform Limited Liability Company Act[~~, as appropriate pursuant to Section 48-3a-1405~~], as well as the applicable provisions in this chapter.

(b) If a conflict exists between a provision of the limited liability company law and a provision of this chapter, this chapter controls.

(c) The provisions of this title pertaining to a merger, consolidation, conversion, mutualization, and redomestication apply in determining the procedures to be followed by a captive insurance company in carrying out any of the transactions described in those provisions.

(d) Notwithstanding Subsection [~~(16)~~] (15)(c), the commissioner may waive or modify the requirements for public notice and hearing in accordance with rules adopted under Section 31A-37-106.

(e) If a notice of public hearing is required, but no one requests a hearing, the commissioner may cancel the public hearing.

[~~(17) (a) A captive insurance company formed as a reciprocal insurer under this chapter has the powers set forth in Section 31A-4-114 in addition to the applicable provisions of this chapter.~~]

[~~(b) If a conflict exists between the provisions of Section 31A-4-114 and the provisions of this chapter with respect to a captive insurance company, this chapter shall control.~~]

[~~(c) To the extent a reciprocal insurer is made subject to other provisions of this title pursuant to Section 31A-14-208, the provisions are not applicable to a reciprocal insurer formed under this chapter unless the provisions are expressly made applicable to a captive insurance company under this chapter.~~]

[~~(d) In addition to the provisions of this Subsection (17), a captive insurance company organized as a reciprocal insurer that is an industrial insured group has the privileges of Section 31A-4-114 in addition to applicable provisions of this title.~~]

[~~(18)~~] (16) (a) The articles of incorporation or bylaws of a captive insurance company formed as a corporation may not authorize a quorum of a board of directors to consist of fewer than one-third of the fixed or prescribed number of directors as provided in Section 16-10a-824.

(b) The certificate of organization of a captive insurance company formed as a limited liability company may not authorize a quorum of a board of managers to consist of fewer than

one-third of the fixed or prescribed number of directors required in Section 16-10a-824.

Section 63. Section **31A-37-303** is amended to read:

31A-37-303. Reinsurance.

(1) A captive insurance company may cede risks to any insurance company approved by the commissioner. A captive insurance company may provide reinsurance, as authorized in this title, on risks ceded for the benefit of a parent, affiliate, or controlled unaffiliated business.

(2) (a) A captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers if the captive insurance company complies with Section 31A-17-404, 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or if the captive insurance company complies with other requirements as the commissioner may establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) Unless the reinsurer is in compliance with Section 31A-17-404, 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or a rule adopted under Subsection (2)(a), a captive insurance company may not take credit for:

(i) reserves on risks ceded to a reinsurer; or

(ii) portions of risks ceded to a reinsurer.

Section 64. Section **31A-37-305** is amended to read:

31A-37-305. Contributions to guaranty or insolvency fund prohibited.

(1) A captive insurance company[~~, including a captive insurance company organized as a reciprocal insurer under this chapter,~~] may not join or contribute financially to any of the following in this state:

(a) a plan;

(b) a pool;

(c) an association;

(d) a guaranty fund; or

(e) an insolvency fund.

(2) A captive insurance company, the insured of a captive insurance company, the

parent of a captive insurance company, an affiliate of a captive insurance company, or a member organization of an association captive insurance company[~~, or in the case of a captive insurance company organized as a reciprocal insurer, a subscriber of the captive insurance company,~~] may not receive a benefit from:

(a) a plan;

(b) a pool;

(c) an association;

(d) a guaranty fund for claims arising out of the operations of the captive insurance company; or

(e) an insolvency fund for claims arising out of the operations of the captive insurance company.

Section 65. Section **31A-42-201** is amended to read:

31A-42-201. Creation of risk adjuster mechanism -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.

(1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity within the department.

(2) (a) The risk adjuster is under the direction of a board of directors composed of up to nine members described in Subsection (2)(b).

(b) The board of directors shall consist of:

(i) the following directors appointed by the governor with the consent of the Senate:

(A) at least [~~three~~] one, but up to five, directors with actuarial experience who represent insurers[~~: (I)~~] that are participating or have committed to participate in the defined contribution arrangement market in the state; [~~and~~]

[~~(II) including at least one and up to two directors who represent an insurer that has a small percentage of lives in the defined contribution market;~~]

(B) one director who represents either an individual employee or employer; and

(C) one director who represents the Office of Consumer Health Services within the

Governor's Office of Economic Development;

(ii) one director representing the Public Employees' Benefit and Insurance Program with actuarial experience, appointed by the director of the Public Employees' Benefit and Insurance Program; and

(iii) the commissioner, or a representative of the commissioner who:

(A) is appointed by the commissioner; and

(B) has actuarial experience.

(c) The commissioner, or a representative appointed by the commissioner may vote only in the event of a tie vote.

(3) (a) Except as required by Subsection (3)(b), as terms of current board members appointed by the governor expire, the governor shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(c) Notwithstanding the requirements of Subsection (3)(a), a board member shall continue to serve until the board member is reappointed or replaced by another individual in accordance with this section.

(4) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term in the same manner as the original appointment was made.

(5) (a) A board member who is not a government employee may not receive compensation or benefits for the board member's services.

(b) A state government member who is a board member because of the board member's state government position may not receive per diem or expenses for the member's service.

(6) The board shall elect annually a chair and vice chair from its membership.

(7) A majority of the board members is a quorum for the transaction of business.

(8) The action of a majority of the members of the quorum is the action of the board.

Section 66. Section **31A-44-603** is amended to read:

31A-44-603. Examinations.

(1) The department may conduct periodic on-site examinations of a provider.

(2) In conducting an examination, the department or the department's staff:

(a) shall have full and free access to all the provider's records; and

(b) may summon and qualify as a witness, under oath, and examine, any director, officer, member, agent, or employee of the provider, and any other person, concerning the condition and affairs of the provider or a facility.

(3) Books and records shall be kept for not less than three calendar years in addition to the current calendar year.

[~~(3)~~] (4) The provider shall pay the reasonable costs of an examination under this section.

[~~(4)~~] (5) The department may conduct an on-site examination in conjunction with an examination performed by a representative of an agency of another state.

[~~(5)~~] (6) (a) The department, in lieu of an on-site examination, may accept the examination report of an agency of another state that has regulatory oversight of the provider, or a report prepared by an independent accounting firm.

(b) A report accepted under Subsection [~~(5)~~] (6)(a) is considered for all purposes an official report of the department.

[~~(6)~~] (7) Upon reasonable cause, the department may conduct an on-site examination of an unlicensed person to determine whether a violation of this chapter has occurred.

Section 67. Section **53-2a-1102** is amended to read:

53-2a-1102. Search and Rescue Financial Assistance Program -- Uses -- Rulemaking -- Distribution.

(1) (a) "Assistance card program" means the Utah Search and Rescue Assistance Card Program created within this section.

(b) "Card" means the Search and Rescue Assistance Card issued under this section to a participant.

(c) "Participant" means an individual, family, or group who is registered pursuant to this section as having a valid card at the time search, rescue, or both are provided.

(d) "Program" means the Search and Rescue Financial Assistance Program created within this section.

(e) (i) "Reimbursable expenses," as used in this section, means those reasonable expenses incidental to search and rescue activities.

(ii) "Reimbursable expenses" include:

(A) rental for fixed wing aircraft, helicopters, snowmobiles, boats, and generators;

(B) replacement and upgrade of search and rescue equipment;

(C) training of search and rescue volunteers;

(D) costs of providing workers' compensation benefits for volunteer search and rescue team members under Section 67-20-7.5; and

(E) any other equipment or expenses necessary or appropriate for conducting search and rescue activities.

(iii) "Reimbursable expenses" do not include any salary or overtime paid to any person on a regular or permanent payroll, including permanent part-time employees of any agency of the state.

(f) "Rescue" means search services, rescue services, or both search and rescue services.

(2) There is created the Search and Rescue Financial Assistance Program within the division.

(3) (a) The program shall be funded from the following revenue sources:

(i) any voluntary contributions to the state received for search and rescue operations;

(ii) money received by the state under Subsection (11) and under Sections 23-19-42, 41-22-34, and 73-18-24; and

(iii) appropriations made to the program by the Legislature.

(b) All money received from the revenue sources in Subsections (3)(a)(i) and (ii) shall be deposited into the General Fund as a dedicated credit to be used solely for the purposes under this section.

(c) All funding for the program is nonlapsing.

(4) The director shall use the money to reimburse counties for all or a portion of each county's reimbursable expenses for search and rescue operations, subject to:

(a) the approval of the Search and Rescue Advisory Board as provided in Section 53-2a-1104;

(b) money available in the program; and

(c) rules made under Subsection (7).

(5) Program money may not be used to reimburse for any paid personnel costs or paid man hours spent in emergency response and search and rescue related activities.

(6) The Legislature finds that these funds are for a general and statewide public purpose.

(7) The division, with the approval of the Search and Rescue Advisory Board, shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and consistent with this section:

(a) specifying the costs that qualify as reimbursable expenses;

(b) defining the procedures of counties to submit expenses and be reimbursed;

(c) defining a participant in the assistance card program, including:

(i) individuals; and

(ii) families and organized groups who qualify as participants;

(d) defining the procedure for issuing a card to a participant;

(e) defining excluded expenses that may not be reimbursed under the program, including medical expenses;

(f) establishing the card renewal cycle for the Utah Search and Rescue Assistance Card Program;

(g) establishing the frequency of review of the fee schedule;

(h) providing for the administration of the program; and

(i) providing a formula to govern the distribution of available money among the counties for uncompensated search and rescue expenses based on:

(i) the total qualifying expenses submitted;

(ii) the number of search and rescue incidents per county population;

(iii) the number of victims that reside outside the county; and

(iv) the number of volunteer hours spent in each county in emergency response and search and rescue related activities per county population.

(8) (a) The division shall, in consultation with the Outdoor Recreation Office, establish the fee schedule of the Search and Rescue Assistance Card under Subsection 63J-1-504(6).

(b) The division shall provide a discount of not less than 10% of the card fee under Subsection (8)(a) to a person who has paid a fee under Section 23-19-42, 41-22-34, or 73-18-24 during the same calendar year in which the person applies to be a participant in the assistance card program.

(9) (a) Counties may bill reimbursable expenses to an individual for costs incurred for the rescue of an individual, if the individual is not a participant in the Utah Search and Rescue Assistance Card Program.

(b) Counties may bill a participant for reimbursable expenses for costs incurred for the rescue of the participant if the participant is found by the rescuing county to have acted recklessly or to have intentionally created a situation resulting in the need for a county to provide rescue service for the participant.

(10) (a) There is created the Utah Search and Rescue Assistance Card Program. The program is located within the division.

(b) The program may not be utilized to cover any expenses, such as medically related expenses, that are not reimbursable expenses related to the rescue.

(11) (a) To participate in the program, a person shall purchase a Search and Rescue

Assistance Card from the division by paying the fee as determined by the division in Subsection (8).

(b) The money generated by the fees shall be deposited into the General Fund as a dedicated credit for the Search and Rescue Financial Assistance Program created in this section.

(c) Participation and payment of fees by a person under Sections 23-19-42, 41-22-34, and 73-18-24 do not constitute purchase of a card under this section.

(12) The division shall consult with the Outdoor Recreation Office regarding:

(a) administration of the assistance card program; and

(b) outreach and marketing strategies.

(13) Pursuant to Subsection 31A-1-103(7), the Utah Search and Rescue Assistance Card Program under this section is exempt from being considered [~~an~~] insurance [~~program under Subsection~~] as defined in Section 31A-1-301[~~(86)~~].

Section 68. Section **59-7-102** is amended to read:

59-7-102. Exemptions.

(1) Except as provided in this section, the following are exempt from a tax under this chapter:

(a) an organization exempt under Section 501, Internal Revenue Code;

(b) an organization exempt under Section 528, Internal Revenue Code;

(c) an insurance company that is subject to taxation on the insurance company's premiums under Chapter 9, Taxation of Admitted Insurers, regardless of whether the insurance company has a tax liability under that chapter;

(d) a local building authority as defined in Section 17D-2-102;

(e) a farmers' cooperative; [~~or~~]

(f) a public agency, as defined in Section 11-13-103, with respect to or as a result of an ownership interest in:

(i) a project, as defined in Section 11-13-103; or

(ii) facilities providing additional project capacity, as defined in Section 11-13-103[.];

(g) an insurance company that engages in a transaction that is subject to taxation under Section 31A-3-301 or 31A-3-302, regardless of whether the insurance company has a tax liability under that section; or

(h) a captive insurance company that pays a fee under Section 31A-3-304.

(2) A corporation is exempt from a tax under this chapter:

(a) if the corporation is an out-of-state business as defined in Section 53-2a-1202; and

(b) for income earned:

(i) during a disaster period as defined in Section 53-2a-1202; and

(ii) for the purpose of responding to a declared state disaster or emergency as defined in Section 53-2a-1202.

(3) Notwithstanding any other provision in this chapter or Chapter 8, Gross Receipts Tax on Certain Corporations Not Required to Pay Corporate Franchise or Income Tax Act, a person not otherwise subject to the tax imposed by this chapter or Chapter 8, Gross Receipts Tax on Certain Corporations Not Required to Pay Corporate Franchise or Income Tax Act, is not subject to a tax imposed by Section 59-7-104, 59-7-201, 59-7-701, or 59-8-104, because of:

(a) that person's ownership of tangible personal property located at the premises of a printer's facility in this state with which the person has contracted for printing; or

(b) the activities of the person's employees or agents who are:

(i) located solely at the premises of a printer's facility; and

(ii) performing services:

(A) related to:

(I) quality control;

(II) distribution; or

(III) printing services; and

(B) performed by the printer's facility in this state with which the person has contracted for printing.

(4) Notwithstanding Subsection (1), an organization, company, authority, farmers' cooperative, or public agency exempt from this chapter under Subsection (1) is subject to Part 8, Unrelated Business Income, to the extent provided in Part 8, Unrelated Business Income.

(5) Notwithstanding Subsection (1)(b), to the extent the income of an organization described in Subsection (1)(b) is taxable for federal tax purposes under Section 528, Internal Revenue Code, the organization's income is also taxable under this chapter.

Section 69. Section **59-9-101** is amended to read:

59-9-101. Tax basis -- Rates -- Exemptions -- Rate reductions.

(1) (a) Except as provided in Subsection (1)(b), (1)(d), or (5), an admitted insurer shall pay to the commission on or before March 31 in each year, a tax of 2-1/4% of the total premiums received by it during the preceding calendar year from insurance covering property or risks located in this state.

(b) This Subsection (1) does not apply to:

(i) workers' compensation insurance, assessed under Subsection (2);

(ii) title insurance premiums taxed under Subsection (3);

(iii) annuity considerations;

(iv) insurance premiums paid by an institution within the state system of higher education as specified in Section 53B-1-102; and

(v) ocean marine insurance.

(c) The taxable premium under this Subsection (1) shall be reduced by:

(i) the premiums returned or credited to policyholders on direct business subject to tax in this state;

(ii) the premiums received for reinsurance of property or risks located in this state; and

(iii) the dividends, including premium reduction benefits maturing within the year:

(A) paid or credited to policyholders in this state; or

(B) applied in abatement or reduction of premiums due during the preceding calendar year.

(d) (i) For purposes of this Subsection (1)(d):

(A) "Utah variable life insurance premium" means an insurance premium paid:

(I) by:

(Aa) a corporation; or

(Bb) a trust established or funded by a corporation; and

(II) for variable life insurance covering risks located within the state.

(B) "Variable life insurance" means an insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of one or more separate accounts that are established and maintained by the insurer pursuant to Title 31A, Insurance Code.

(ii) Notwithstanding Subsection (1)(a), beginning on January 1, 2006, the tax on that portion of the total premiums subject to a tax under Subsection (1)(a) that is a Utah variable life insurance premium shall be calculated as follows:

(A) 2-1/4% of the first $100,000 of Utah variable life insurance premiums:

(I) paid for each variable life insurance policy; and

(II) received by the admitted insurer in the preceding calendar year; and

(B) 0.08% of the Utah variable life insurance premiums that exceed $100,000:

(I) paid for the policy described in Subsection (1)(d)(ii)(A); and

(II) received by the admitted insurer in the preceding calendar year.

(2) (a) An admitted insurer writing workers' compensation insurance in this state, including the Workers' Compensation Fund created under Title 31A, Chapter 33, Workers' Compensation Fund, shall pay to the tax commission, on or before March 31 in each year, a premium assessment on the basis of the total workers' compensation premium income received by the insurer from workers' compensation insurance in this state during the preceding calendar year as follows:

(i) on or before December 31, 2010, an amount of equal to or greater than 1%, but equal to or less than 5.75% of the total workers' compensation premium income described in

this Subsection (2);

(ii) on and after January 1, 2011, but on or before December 31, 2017, an amount of equal to or greater than 1%, but equal to or less than 4.25% of the total workers' compensation premium income described in this Subsection (2); and

(iii) on and after January 1, 2018, an amount equal to 1.25% of the total workers' compensation premium income described in this Subsection (2).

(b) Total workers' compensation premium income means the net written premium as calculated before any premium reduction for any insured employer's deductible, retention, or reimbursement amounts and also those amounts equivalent to premiums as provided in Section 34A-2-202.

(c) The percentage of premium assessment applicable for a calendar year shall be determined by the Labor Commission under Subsection (2)(d). The total premium income shall be reduced in the same manner as provided in Subsections (1)(c)(i) and (1)(c)(ii), but not as provided in Subsection (1)(c)(iii). The commission shall promptly remit from the premium assessment collected under this Subsection (2):

(i) income to the state treasurer for credit to the Employers' Reinsurance Fund created under Subsection 34A-2-702(1) as follows:

(A) on or before December 31, 2009, an amount of up to 5% of the total workers' compensation premium income;

(B) on and after January 1, 2010, but on or before December 31, 2010, an amount of up to 4.5% of the total workers' compensation premium income;

(C) on and after January 1, 2011, but on or before December 31, 2017, an amount of up to 3% of the total workers' compensation premium income; and

(D) on and after January 1, 2018, 0% of the total workers' compensation premium income;

(ii) an amount equal to 0.25% of the total workers' compensation premium income to the state treasurer for credit to the Workplace Safety Account created by Section 34A-2-701;

(iii) an amount of up to 0.5% and any remaining assessed percentage of the total workers' compensation premium income to the state treasurer for credit to the Uninsured Employers' Fund created under Section 34A-2-704; and

(iv) beginning on January 1, 2010, 0.5% of the total workers' compensation premium income to the state treasurer for credit to the Industrial Accident Restricted Account created in Section 34A-2-705.

(d) (i) The Labor Commission shall determine the amount of the premium assessment for each year on or before each October 15 of the preceding year. The Labor Commission shall make this determination following a public hearing. The determination shall be based upon the recommendations of a qualified actuary.

(ii) The actuary shall recommend a premium assessment rate sufficient to provide payments of benefits and expenses from the Employers' Reinsurance Fund and to project a funded condition with assets greater than liabilities by no later than June 30, 2025.

(iii) The actuary shall recommend a premium assessment rate sufficient to provide payments of benefits and expenses from the Uninsured Employers' Fund and to maintain it at a funded condition with assets equal to or greater than liabilities.

(iv) At the end of each fiscal year the minimum approximate assets in the Employers' Reinsurance Fund shall be $5,000,000 which amount shall be adjusted each year beginning in 1990 by multiplying by the ratio that the total workers' compensation premium income for the preceding calendar year bears to the total workers' compensation premium income for the calendar year 1988.

(v) The requirements of Subsection (2)(d)(iv) cease when the future annual disbursements from the Employers' Reinsurance Fund are projected to be less than the calculations of the corresponding future minimum required assets. The Labor Commission shall, after a public hearing, determine if the future annual disbursements are less than the corresponding future minimum required assets from projections provided by the actuary.

(vi) At the end of each fiscal year the minimum approximate assets in the Uninsured

Employers' Fund shall be $2,000,000, which amount shall be adjusted each year beginning in 1990 by multiplying by the ratio that the total workers' compensation premium income for the preceding calendar year bears to the total workers' compensation premium income for the calendar year 1988.

(e) A premium assessment that is to be transferred into the General Fund may be collected on premiums received from Utah public agencies.

(3) An admitted insurer writing title insurance in this state shall pay to the commission, on or before March 31 in each year, a tax of .45% of the total premium received by either the insurer or by its agents during the preceding calendar year from title insurance concerning property located in this state. In calculating this tax, "premium" includes the charges made to an insured under or to an applicant for a policy or contract of title insurance for:

(a) the assumption by the title insurer of the risks assumed by the issuance of the policy or contract of title insurance; and

(b) abstracting title, title searching, examining title, or determining the insurability of title, and every other activity, exclusive of escrow, settlement, or closing charges, whether denominated premium or otherwise, made by a title insurer, an agent of a title insurer, a title insurance producer, or any of them.

(4) Beginning July 1, 1986, a former county mutual and a former mutual benefit association shall pay the premium tax or assessment due under this chapter. Premiums received after July 1, 1986, shall be considered in determining the tax or assessment.

(5) The following insurers are not subject to the premium tax on health care insurance that would otherwise be applicable under Subsection (1):

(a) an insurer licensed under Title 31A, Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(b) an insurer licensed under Title 31A, Chapter 7, Nonprofit Health Service Insurance Corporations;

(c) an insurer licensed under Title 31A, Chapter 8, Health Maintenance Organizations

and Limited Health Plans;

(d) an insurer licensed under Title 31A, Chapter 9, Insurance Fraternals;

(e) an insurer licensed under Title 31A, Chapter 11, Motor Clubs;

(f) an insurer licensed under Title 31A, Chapter 13, Employee Welfare Funds and Plans; and

(g) an insurer licensed under Title 31A, Chapter 14, Foreign Insurers.

(6) A captive insurer, as provided in Section 31A-3-304, that pays a fee imposed under Section 31A-3-304 is not subject to the premium tax under this section.

[~~(6)~~] (7) An insurer issuing multiple policies to an insured may not artificially allocate the premiums among the policies for purposes of reducing the aggregate premium tax or assessment applicable to the policies.

[~~(7)~~] (8) The retaliatory provisions of Title 31A, Chapter 3, Department Funding, Fees, and Taxes, apply to the tax or assessment imposed under this chapter.

Section 70. Section **63G-2-302** is amended to read:

63G-2-302. Private records.

(1) The following records are private:

(a) records concerning an individual's eligibility for unemployment insurance benefits, social services, welfare benefits, or the determination of benefit levels;

(b) records containing data on individuals describing medical history, diagnosis, condition, treatment, evaluation, or similar medical data;

(c) records of publicly funded libraries that when examined alone or with other records identify a patron;

(d) records received by or generated by or for:

(i) the Independent Legislative Ethics Commission, except for:

(A) the commission's summary data report that is required under legislative rule; and

(B) any other document that is classified as public under legislative rule; or

(ii) a Senate or House Ethics Committee in relation to the review of ethics complaints,

unless the record is classified as public under legislative rule;

(e) records received by, or generated by or for, the Independent Executive Branch Ethics Commission, except as otherwise expressly provided in Title 63A, Chapter 14, Review of Executive Branch Ethics Complaints;

(f) records received or generated for a Senate confirmation committee concerning character, professional competence, or physical or mental health of an individual:

(i) if, prior to the meeting, the chair of the committee determines release of the records:

(A) reasonably could be expected to interfere with the investigation undertaken by the committee; or

(B) would create a danger of depriving a person of a right to a fair proceeding or impartial hearing; and

(ii) after the meeting, if the meeting was closed to the public;

(g) employment records concerning a current or former employee of, or applicant for employment with, a governmental entity that would disclose that individual's home address, home telephone number, social security number, insurance coverage, marital status, or payroll deductions;

(h) records or parts of records under Section 63G-2-303 that a current or former employee identifies as private according to the requirements of that section;

(i) that part of a record indicating a person's social security number or federal employer identification number if provided under Section 31A-23a-104, 31A-25-202, 31A-26-202, 58-1-301, 58-55-302, 61-1-4, or 61-2f-203;

(j) that part of a voter registration record identifying a voter's:

(i) driver license or identification card number;

(ii) Social Security number, or last four digits of the Social Security number;

(iii) email address; or

(iv) date of birth;

(k) a voter registration record that is classified as a private record by the lieutenant

governor or a county clerk under Subsection 20A-2-104(4)(f) or 20A-2-101.1(5)(a);

(l) a record that:

(i) contains information about an individual;

(ii) is voluntarily provided by the individual; and

(iii) goes into an electronic database that:

(A) is designated by and administered under the authority of the Chief Information Officer; and

(B) acts as a repository of information about the individual that can be electronically retrieved and used to facilitate the individual's online interaction with a state agency;

(m) information provided to the Commissioner of Insurance under:

(i) Subsection 31A-23a-115[~~(2)~~](3)(a);

(ii) Subsection 31A-23a-302[~~(3)~~](4); or

(iii) Subsection 31A-26-210[~~(3)~~](4);

(n) information obtained through a criminal background check under Title 11, Chapter 40, Criminal Background Checks by Political Subdivisions Operating Water Systems;

(o) information provided by an offender that is:

(i) required by the registration requirements of Title 77, Chapter 41, Sex and Kidnap Offender Registry; and

(ii) not required to be made available to the public under Subsection 77-41-110(4);

(p) a statement and any supporting documentation filed with the attorney general in accordance with Section 34-45-107, if the federal law or action supporting the filing involves homeland security;

(q) electronic toll collection customer account information received or collected under Section 72-6-118 and customer information described in Section 17B-2a-815 received or collected by a public transit district, including contact and payment information and customer travel data;

(r) an email address provided by a military or overseas voter under Section

20A-16-501;

(s) a completed military-overseas ballot that is electronically transmitted under Title 20A, Chapter 16, Uniform Military and Overseas Voters Act;

(t) records received by or generated by or for the Political Subdivisions Ethics Review Commission established in Section 11-49-201, except for:

(i) the commission's summary data report that is required in Section 11-49-202; and

(ii) any other document that is classified as public in accordance with Title 11, Chapter 49, Political Subdivisions Ethics Review Commission;

(u) a record described in Subsection 53A-11a-203(3) that verifies that a parent was notified of an incident or threat; and

(v) a criminal background check or credit history report conducted in accordance with Section 63A-3-201.

(2) The following records are private if properly classified by a governmental entity:

(a) records concerning a current or former employee of, or applicant for employment with a governmental entity, including performance evaluations and personal status information such as race, religion, or disabilities, but not including records that are public under Subsection 63G-2-301(2)(b) or 63G-2-301(3)(o) or private under Subsection (1)(b);

(b) records describing an individual's finances, except that the following are public:

(i) records described in Subsection 63G-2-301(2);

(ii) information provided to the governmental entity for the purpose of complying with a financial assurance requirement; or

(iii) records that must be disclosed in accordance with another statute;

(c) records of independent state agencies if the disclosure of those records would conflict with the fiduciary obligations of the agency;

(d) other records containing data on individuals the disclosure of which constitutes a clearly unwarranted invasion of personal privacy;

(e) records provided by the United States or by a government entity outside the state

that are given with the requirement that the records be managed as private records, if the providing entity states in writing that the record would not be subject to public disclosure if retained by it;

(f) any portion of a record in the custody of the Division of Aging and Adult Services, created in Section 62A-3-102, that may disclose, or lead to the discovery of, the identity of a person who made a report of alleged abuse, neglect, or exploitation of a vulnerable adult; and

(g) audio and video recordings created by a body-worn camera, as defined in Section 77-7a-103, that record sound or images inside a home or residence except for recordings that:

(i) depict the commission of an alleged crime;

(ii) record any encounter between a law enforcement officer and a person that results in death or bodily injury, or includes an instance when an officer fires a weapon;

(iii) record any encounter that is the subject of a complaint or a legal proceeding against a law enforcement officer or law enforcement agency;

(iv) contain an officer involved critical incident as defined in Section 76-2-408(1)(d); or

(v) have been requested for reclassification as a public record by a subject or authorized agent of a subject featured in the recording.

(3) (a) As used in this Subsection (3), "medical records" means medical reports, records, statements, history, diagnosis, condition, treatment, and evaluation.

(b) Medical records in the possession of the University of Utah Hospital, its clinics, doctors, or affiliated entities are not private records or controlled records under Section 63G-2-304 when the records are sought:

(i) in connection with any legal or administrative proceeding in which the patient's physical, mental, or emotional condition is an element of any claim or defense; or

(ii) after a patient's death, in any legal or administrative proceeding in which any party relies upon the condition as an element of the claim or defense.

(c) Medical records are subject to production in a legal or administrative proceeding

according to state or federal statutes or rules of procedure and evidence as if the medical records were in the possession of a nongovernmental medical care provider.

Section 71. **Repealer.**

This bill repeals:

Section **31A-22-715, Alcohol and drug dependency treatment.**

Section **31A-22-718, Dependent coverage.**

Section **31A-34-101, Title.**

Section **31A-34-102, Purpose and intent -- Legislative findings.**

Section **31A-34-103, Definitions.**

Section **31A-34-104, Alliance -- Required license.**

Section **31A-34-105, Association requirements.**

Section **31A-34-106, Jurisdiction of the commissioner.**

Section **31A-34-107, Directors, trustees, and officers.**

Section **31A-34-108, Powers of and restrictions on alliances.**

Section **31A-34-109, Operation of alliances.**

Section **31A-34-110, Contracts with member employers and contracted insurers.**

Section **31A-34-111, Alliance evaluation.**

Section **31A-37-306, Conversion or merger.**

Section 72. **Retrospective operation.**

(1) The amendments in this bill to Section 31A-3-102 and Section 59-7-102 have retrospective operation for a taxable year beginning on or after January 1, 2017.

(2) The amendments in this bill to Section 59-9-101 have retrospective operation to January 1, 2017.