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H.B. 19

INSURANCE LAW RELATED AMENDMENTS

2011 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

Committee Note:

The Business and Labor Interim Committee recommended this bill.

General Description:

This bill modifies the Insurance Code and other provisions related to the regulation of insurance and insurance products.

Highlighted Provisions:

This bill:

- amends definitions;
- addresses fees for captive insurance companies and the cap on the Captive Insurance Restricted Account;
- modifies restrictions on foreign title insurers;
- addresses grace periods for accident and health insurance policies;
- modifies provisions related to individuals, group, or blanket accident and health insurance coverage;
- addresses producer lines of authority;
- addresses a written agreement related to a voluntary surrender of a license;
- amends provisions related to continuing education;
- provides for training related to long-term care insurance;
- modifies title insurance agency and producer licensing requirements;
- addresses when a title insurance producer may do an escrow involving a real

H.B. 19

property transaction;

- modifies provisions related to disbursements from escrow accounts;
- addresses when a person may represent that the person acts in behalf of an insurer;
- modifies provisions related to providing the commissioner address, telephone, and email address information;
- addresses verification under a nonresident jurisdictional agreement;
- addresses per diem and travel expenses of public representatives on the board of directors of the Utah Life and Health Insurance Guaranty Association;
- addresses the establishment of classes of business;
- modifies rating restrictions;
- addresses the renewal of a bail bond surety company license;
- permits the commissioner to assign a department employee to engage in certain activities related to the regulation of captive insurance companies;
- requires a professional employer organization to notify the commissioner of material changes;
- removes the title insurance assessment from the sunset act;
- converts certain dedicated credits into several restricted accounts and provides that related appropriations are nonlapsing; and
- makes technical and conforming amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill has an effective date.

This bill provides for retrospective operation of certain provisions.

Utah Code Sections Affected:

AMENDS:

31A-1-301, as last amended by Laws of Utah 2010, Chapter 10

31A-2-208, as last amended by Laws of Utah 2010, Chapter 391

31A-2-212, as last amended by Laws of Utah 2007, Chapter 309

31A-3-304, as last amended by Laws of Utah 2010, Chapters 10, 68 and last amended by Coordination Clause, Laws of Utah 2010, Chapter 265

31A-14-211, as last amended by Laws of Utah 2003, Chapter 298
31A-22-607, as last amended by Laws of Utah 2004, Chapter 329
31A-22-610.6, as enacted by Laws of Utah 2008, Chapters 345, 383, and 390
31A-22-614.5, as last amended by Laws of Utah 2010, Chapter 357
31A-22-625, as last amended by Laws of Utah 2010, Chapters 10 and 68
31A-22-701, as last amended by Laws of Utah 2010, Chapter 10
31A-22-716, as last amended by Laws of Utah 2005, Chapter 71
31A-22-721, as last amended by Laws of Utah 2004, Chapter 329
31A-22-723, as last amended by Laws of Utah 2010, Chapter 68
31A-23a-102, as last amended by Laws of Utah 2009, Chapter 349
31A-23a-106, as last amended by Laws of Utah 2009, Chapter 349
31A-23a-111, as last amended by Laws of Utah 2009, Chapters 349 and 355
31A-23a-202, as last amended by Laws of Utah 2009, Chapter 127
31A-23a-203, as last amended by Laws of Utah 2009, Chapter 349
31A-23a-204, as last amended by Laws of Utah 2009, Chapter 349
31A-23a-406, as last amended by Laws of Utah 2007, Chapter 325
31A-23a-408, as renumbered and amended by Laws of Utah 2003, Chapter 298
31A-23a-412, as renumbered and amended by Laws of Utah 2003, Chapter 298
31A-25-208, as last amended by Laws of Utah 2009, Chapter 349
31A-26-206, as last amended by Laws of Utah 2008, Chapter 382
31A-26-208, as last amended by Laws of Utah 2008, Chapter 3
31A-26-213, as last amended by Laws of Utah 2009, Chapter 349
31A-26-306, as last amended by Laws of Utah 2004, Chapter 173
31A-28-107, as last amended by Laws of Utah 2010, Chapter 292
31A-29-103, as last amended by Laws of Utah 2008, Chapters 3 and 385
31A-29-106, as last amended by Laws of Utah 2008, Chapter 382
31A-30-103, as last amended by Laws of Utah 2010, Chapter 68
31A-30-105, as last amended by Laws of Utah 2010, Chapter 68
31A-30-106, as last amended by Laws of Utah 2010, Chapter 68
31A-30-106.1, as enacted by Laws of Utah 2010, Chapter 68
31A-30-106.5, as last amended by Laws of Utah 2010, Chapter 68

31A-30-108, as last amended by Laws of Utah 2008, Chapter 383
31A-30-110, as last amended by Laws of Utah 2002, Chapter 308
31A-30-112, as last amended by Laws of Utah 2009, Chapter 12
31A-31-108, as last amended by Laws of Utah 2010, Chapter 391
31A-31-109, as last amended by Laws of Utah 2010, Chapter 391
31A-35-202, as last amended by Laws of Utah 2000, Chapter 259
31A-35-406, as last amended by Laws of Utah 2010, Chapter 10
31A-35-602, as last amended by Laws of Utah 2000, Chapter 259
31A-37-103, as last amended by Laws of Utah 2008, Chapter 302
31A-37-202, as last amended by Laws of Utah 2009, Chapter 183
31A-37-504, as last amended by Laws of Utah 2007, Chapter 309
59-9-105, as last amended by Laws of Utah 2002, Chapter 308
63I-2-231, as last amended by Laws of Utah 2010, Chapters 68 and 285
63J-1-602.2, as enacted by Laws of Utah 2010, Chapter 265 and last amended by Coordination Clause, Laws of Utah 2010, Chapter 265
63J-1-602.3, as enacted by Laws of Utah 2010, Chapter 265

ENACTS:

31A-40-308, Utah Code Annotated 1953

Uncodified Material Affected:

ENACTS UNCODIFIED MATERIAL

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

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

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

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

(3) "Administrator" is defined in Subsection [~~(159)~~] (161).

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

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

(6) "Agency" means:

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

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

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

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

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

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

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

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

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

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

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

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

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

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

(a) without individual underwriting or application; and

(b) that is determined by definition [~~with or~~] without designating each person covered.

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

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

(a) that is open to the public;

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

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

[~~(16)~~] (17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

[~~(17)~~] (18) "Business of insurance" is defined in Subsection [~~(85)~~] (87).

[~~(18)~~] (19) "Business plan" means the information required to be supplied to the commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when these subsections apply by reference under:

(a) Section 31A-7-201;

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

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

[~~(19)~~] (20) (a) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated.

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

[~~(20)~~] (21) "Captive insurance company" means:

(a) an insurer:

(i) owned by another organization; and

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

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

(i) owned by the insureds; and

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

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

[~~(21)~~] (22) "Casualty insurance" means liability insurance.

[~~(22)~~] (23) "Certificate" means evidence of insurance given to:

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

(b) a third party.

[~~(23)~~] (24) "Certificate of authority" is included within the term "license."

[~~(24)~~] (25) "Claim," unless the context otherwise requires, means a request or demand on an insurer for payment of a benefit according to the terms of an insurance policy.

[~~(25)~~] (26) "Claims-made coverage" means an insurance contract or provision limiting coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force.

[~~(26)~~] (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance commissioner.

(b) When appropriate, the terms listed in Subsection [~~(26)~~] (27)(a) apply to the equivalent supervisory official of another jurisdiction.

[~~(27)~~] (28) (a) "Continuing care insurance" means insurance that:

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

(iii) provides the coverage described in this Subsection [~~(27)~~] (28)(a) under an agreement effective:

(A) for the life of the insured; or

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

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as a service described in Subsection [~~(27)~~] (28)(a)(ii).

[~~(28)~~] (29) (a) "Control," "controlling," "controlled," or "under common control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person. This control may be:

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections [~~(28)~~] (29)(a)(i) through (iii).

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

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

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

[~~(29)~~] (30) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a producer.

[~~(30)~~] (31) "Controlling person" means a person that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

[~~(31)~~] (32) "Controlling producer" means a producer who directly or indirectly controls an insurer.

[~~(32)~~] (33) (a) "Corporation" means an insurance corporation, except when referring to:

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a limited line producer;

(III) a consultant;

(IV) a managing general agent;

(V) a reinsurance intermediary;

(VI) a third party administrator; or

(VII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

[~~(33)~~] (34) (a) "Creditable coverage" has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act [~~of 1996, Pub. L. 104-191, 110 Stat. 1936~~].

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

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

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

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

[~~(34)~~] (35) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor is disabled.

[~~(35)~~] (36) (a) "Credit insurance" means insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

[~~(36)~~] (37) "Credit life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays a person if the debtor dies.

[~~(37)~~] (38) "Credit property insurance" means insurance:

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

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

[~~(38)~~] (39) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

[~~(39)~~] (40) "Creditor" means a person, including an insured, having a claim, whether:

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

[~~(40)~~] (41) (a) "Customer service representative" means a person that provides an insurance service and insurance product information:

(i) for the customer service representative's:

(A) producer; or

(B) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

[~~(41)~~] (42) "Deadline" means a final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

[~~(42)~~] (43) "Deemer clause" means a provision under this title under which upon the occurrence of a condition precedent, the commissioner is considered to have taken a specific action. If the statute so provides, a condition precedent may be the commissioner's failure to take a specific action.

[~~(43)~~] (44) "Degree of relationship" means the number of steps between two persons determined by counting the generations separating one person from a common ancestor and then counting the generations to the other person.

[~~(44)~~] (45) "Department" means the Insurance Department.

[~~(45)~~] (46) "Director" means a member of the board of directors of a corporation.

[~~(46)~~] (47) "Disability" means a physiological or psychological condition that partially or totally limits an individual's ability to:

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

[~~(47)~~] (48) "Disability income insurance" is defined in Subsection [~~(76)~~] (78).

[~~(48)~~] (49) "Domestic insurer" means an insurer organized under the laws of this state.

[~~(49)~~] (50) "Domiciliary state" means the state in which an insurer:

(a) is incorporated;

(b) is organized; or

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

[~~(50)~~] (51) (a) "Eligible employee" means:

(i) an employee who:

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

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

(ii) a person described in Subsection [~~(50)~~] (51)(b).

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

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection [~~(50)~~] (51)(b):

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

(ii) an employer's spouse; or

(iii) a dependent of an employer.

[~~(51)~~] (52) "Employee" means an individual employed by an employer.

[~~(52)~~] (53) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

[~~(53)~~] (54) (a) "Employee welfare fund" means a fund:

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

(A) one or more employers;

(B) one or more labor organizations; or

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

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

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

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

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

[~~(54)~~] (55) "Endorsement" means a written agreement attached to a policy or certificate to modify the policy or certificate coverage.

[~~(55)~~] (56) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or

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

[~~(56)~~] (57) (a) "Escrow" means:

(i) a real estate settlement or real estate closing conducted by a third party pursuant to the requirements of a written agreement between the parties in a real estate transaction; or

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" includes the act of conducting a:

(i) real estate settlement; or

(ii) real estate closing.

[~~(57)~~] (58) "Escrow agent" means:

(a) an insurance producer with:

(i) a title insurance line of authority; and

(ii) an escrow subline of authority; or

(b) a person defined as an escrow agent in Section 7-22-101.

[~~(58)~~] (59) (a) "Excludes" is not exhaustive and does not mean that another thing is not also excluded.

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

[~~(59)~~] (60) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

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

[~~(60)~~] (61) "Expense reimbursement insurance" means insurance:

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

(b) written:

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

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

[~~(61)~~] (62) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding a position of public or private trust.

[~~(62)~~] (63) (a) "Filed" means that a filing is:

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

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

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

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

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection [~~(62)~~] (63)(a).

[~~(63)~~] (64) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement; or

(o) an outline of coverage.

[~~(64)~~] (65) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay a claim submitted to it by the insured for the insured's losses.

[~~(65)~~] (66) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(66)~~] (67) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

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

[~~(67)~~] (68) "Franchise insurance" means an individual insurance policy provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

[~~(68)~~] (69) "General lines of authority" include:

(a) the general lines of insurance in Subsection [~~(69)~~] (70);

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

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

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

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

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

[~~(69)~~] (70) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

[~~(70)~~] (71) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

[~~(71)~~] (72) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

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

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

(A) the policy; or

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

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

[~~(72)~~] (73) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

[~~(73)~~] (74) (a) Except as provided in Subsection [~~(73)~~] (74)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

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

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

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

(i) provides benefits solely for:

(A) accident;

(B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

(G) vision; or

(H) a short-term limited duration; or

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

[~~(74)~~] (75) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

[~~(75)~~] (76) (a) "Health care insurance" or "health insurance" means insurance

providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

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

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

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

[~~(76)~~] (78) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(77)~~] (79) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(78)~~] (80) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

[~~(79)~~] (81) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(80)~~] (82) "Individual" means a natural person.

[~~(81)~~] (83) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

[~~(82)~~] (84) "Insolvency" means that:

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

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

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

[~~(83)~~] (85) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

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

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

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

[~~(84)~~] (86) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(85)~~] (87) "Insurance business" or "business of insurance" includes:

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

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

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

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

(c) providing an annuity:

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

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

(d) providing the characteristic services of a motor club as outlined in Subsection [~~(113)~~] (115);

(e) providing another person with insurance;

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

[~~(vi)~~] (h) transacting or proposing a life settlement; and

[~~(h)~~] (i) doing, or proposing to do, any business in substance equivalent to Subsections [~~(85)~~] (87)(a) through [~~(g)~~] (h) in a manner designed to evade this title.

[~~(86)~~] (88) "Insurance consultant" or "consultant" means a person who:

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

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

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

[~~(87)~~] (89) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

[~~(88)~~] (90) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

[~~(b) With regards to the selling, soliciting, or negotiating of an insurance product to an~~

~~insurance customer or an insured:~~]

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

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

[~~(ii) "producer~~] (c) (i) "Producer for the insured" means a producer who:

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

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

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

[~~(89)~~] (91) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection [~~(89)~~] (91)(a):

(i) applies only to this title; and

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

[~~(90)~~] (92) (a) "Insurer" means a person doing an insurance business as a principal including:

(i) a fraternal benefit society;

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

(iii) a motor club;

(iv) an employee welfare plan; and

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

(b) "Insurer" does not include a governmental entity to the extent the governmental

entity is engaged in an activity described in Section 31A-12-107.

[~~(91)~~] (93) "Interinsurance exchange" is defined in Subsection [~~(142)~~] (144).

[~~(92)~~] (94) "Involuntary unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

[~~(93)~~] (95) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

[~~(94)~~] (96) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

[~~(95)~~] (97) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

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

(b) through special enrollment.

[~~(96)~~] (98) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal expense.

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

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

[~~(97)~~] (99) (a) "Liability insurance" means insurance against liability:

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

(A) Subsection [~~(107)~~] (109) for medical malpractice insurance;

(B) Subsection [~~(134)~~] (136) for professional liability insurance; and

(C) Subsection [~~(168)~~] (170) for workers' compensation insurance;

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

(A) Subsection [~~(107)~~] (109) for medical malpractice insurance;

(B) Subsection [~~(134)~~] (136) for professional liability insurance; and

(C) Subsection [~~(168)~~] (170) for workers' compensation insurance;

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

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

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

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

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

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

[~~(98)~~] (100) (a) "License" means authorization issued by the commissioner to engage in an activity that is part of or related to the insurance business.

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

[~~(99)~~] (101) (a) "Life insurance" means:

(i) insurance on a human life; and

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

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

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

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

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

[~~(100)~~] (102) "Limited license" means a license that:

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

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

[~~(101)~~] (103) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

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

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

[~~(102)~~] (104) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to an individual through a master, corporate, group, or individual policy.

[~~(103)~~] (105) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) rental car-related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance; and

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

[~~(104)~~] (106) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection [~~(103)~~] (105); and

(b) a customer service representative.

[~~(105)~~] (107) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

[~~(106)~~] (108) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(106)~~] (108)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

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

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

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

[~~(107)~~] (109) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

[~~(108)~~] (110) "Member" means a person having membership rights in an insurance corporation.

[~~(109)~~] (111) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(110)~~] (112) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor is disabled.

[~~(111)~~] (113) "Mortgage guaranty insurance" means surety insurance under which a mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

[~~(112)~~] (114) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

[~~(113)~~] (115) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections [~~(113)~~] (115)(b)(iii)(A) through (D); or

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

[~~(114)~~] (116) "Mutual" means a mutual insurance corporation.

[~~(115)~~] (117) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

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

[~~(116)~~] (118) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive a dividend representing a share of the surplus of the insurer.

[~~(117)~~] (119) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

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

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

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

[~~(118)~~] (120) "Order" means an order of the commissioner.

[~~(119)~~] (121) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(120)~~] (122) "Participating" means a plan of insurance under which the insured is entitled to receive a dividend representing a share of the surplus of the insurer.

[~~(121)~~] (123) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

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

(b) receives:

(i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social

Security Amendments of 1965; or

(ii) another government health benefit.

[~~(122)~~] (124) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

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

[~~(123)~~] (125) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

[~~(124)~~] (126) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

[~~(125)~~] (127) "Plan year" means:

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection [~~(125)~~] (127)(a) or (b), the calendar year.

[~~(126)~~] (128) (a) "Policy" means a document, including an attached endorsement or application that:

(i) purports to be an enforceable contract; and

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

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

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

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

(iii) a corporation licensed under:

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

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

(c) "Policy" does not include:

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

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

[~~(127)~~] (129) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(128)~~] (130) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

[~~(129)~~] (131) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(130)~~] (132) "Preexisting condition," with respect to a health benefit plan:

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

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

[~~(131)~~] (133) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

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

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

[~~(132)~~] (134) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(133)~~] (135) "Proceeding" includes an action or special statutory proceeding.

[~~(134)~~] (136) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

[~~(135)~~] (137) (a) Except as provided in Subsection [~~(135)~~] (137)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

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

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

[~~(136)~~] (138) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(137)~~] (139) "Qualified United States financial institution" means an institution that:

(a) is:

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

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

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

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

(i) the commissioner by rule; or

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

[~~(138)~~] (140) (a) "Rate" means:

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(139)~~] (141) (a) Except as provided in Subsection [~~(139)~~] (141)(b), "rate service organization" means a person who assists an insurer in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

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

[~~(140)~~] (142) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

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

[~~(141)~~] (143) "Received by the department" means:

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

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

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

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

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

[~~(142)~~] (144) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

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

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

[~~(143)~~] (145) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(144)~~] (146) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(145)~~] (147) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(146)~~] (148) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

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

[~~(147)~~] (149) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(148)~~] (150) (a) "Security" means a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed

in Subsections [~~(148)~~] (150)(a)(i) through (xiv); or

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

(b) "Security" does not include:

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

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

[~~(149)~~] (151) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

[~~(150)~~] (152) (a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

[~~(a)~~] (b) Except as provided in this Subsection [~~(150)~~] (152), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

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

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

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

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

[~~(151)~~] (153) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(152)~~] (154) "Short-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.

[~~(153)~~] (155) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.

[~~(154)~~] (156) "Small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

[~~(155)~~] (157) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act [~~of 1996, Pub. L. 104-191, 110 Stat. 1936~~].

[~~(156)~~] (158) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(157)~~] (159) Subject to Subsection [~~(83)~~] (85)(b), "surety insurance" includes:

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

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(158)~~] (160) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

(b) (i) "Permanent surplus" means the surplus of a mutual insurer that is designated by the insurer as permanent.

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

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

(c) "Excess surplus" means:

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

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

(I) 2.5; and

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

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

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(159)~~] (161) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

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

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

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

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

(d) an insurer licensed under [~~Chapter 5, 7, 8, 9, or 14~~] the following, but only for a line of insurance for which the insurer holds a license in this state[~~, or~~]:

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

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

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

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers; or

(e) a person:

(i) licensed or exempt from licensing under:

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

(B) Chapter 26, Insurance Adjusters; and

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

[~~(160)~~] (162) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(161)~~] (163) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

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

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

[~~(162)~~] (164) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

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

[~~(163)~~] (165) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

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

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

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

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

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

[~~(164)~~] (166) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(165)~~] (167) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage under Subsection [~~(135)~~] (137).

[~~(166)~~] (168) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

[~~(167)~~] (169) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

[~~(168)~~] (170) "Workers' compensation insurance" means:

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

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

Section 2. Section **31A-2-208** is amended to read:

31A-2-208. Publications.

(1) The commissioner may prepare and distribute books, pamphlets, and other publications relating to insurance. Except as otherwise provided under this title, the [~~insurance~~] commissioner may charge the cost of producing [~~the publications~~] a publication to those desiring to receive [~~them~~] the publication. Money collected from subscription fees charged for [~~these publications~~] a publication shall be deposited [~~as dedicated credits to be used solely for the production and mailing costs of the publications~~] into the Relative Value Study

Restricted Account, created in Section 59-9-105, to be used as provided in Section 59-9-105.

(2) The commissioner shall have the annual report required in Subsection 31A-2-207(5) printed:

(a) in a form determined by [~~him~~] the commissioner; and

(b) in sufficient numbers to meet [~~all~~] requests for copies.

(3) The commissioner shall publish in [~~his~~] the annual report required in Subsection 31A-2-207(5) an up-to-date chart and explanation of the organization of [~~his~~] the commissioner's office, making clear the allocation of responsibility and authority among the staff. This [~~document~~] up-to-date chart and explanation shall be printed in sufficient numbers [~~sufficient~~] to meet [~~all~~] requests for copies.

Section 3. Section **31A-2-212** is amended to read:

31A-2-212. Miscellaneous duties.

(1) Upon issuance of [~~any~~] an order limiting, suspending, or revoking [~~an insurer's~~] a person's authority to do business in Utah, and [~~on institution of any proceedings~~] when the commissioner begins a proceeding against [~~the~~] an insurer under Chapter 27a, Insurer Receivership Act, the commissioner:

(a) shall notify by mail [~~all agents~~] the producers of the person or insurer of whom the commissioner has record; and

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

(2) When required for evidence in [~~any~~] a legal proceeding, the commissioner shall furnish a certificate of [~~the~~] authority of [~~any~~] a licensee to transact [~~insurance~~] the business of insurance in Utah on any particular date. The court or other officer shall receive the certificate of authority in lieu of the commissioner's testimony.

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

(b) The public officer described in Subsection (3)(a) shall file the certificate of authority furnished under Subsection (3)(a).

(c) After a certified copy of a certificate of authority [~~has been~~] is furnished to a public officer, it is not necessary, while the certificate of authority remains effective, to attach a copy

of it to any instrument of suretyship filed with that public officer.

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

(4) (a) The commissioner shall immediately notify every judge and clerk of [~~all~~] the courts of record in the state when:

(i) an authorized insurer doing a surety business:

(A) files a petition for receivership; or

(B) is in receivership; or

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

(A) is in financial difficulty; or

(B) has unreasonably failed to carry out any of its contracts.

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

(5) The commissioner shall require an insurer that issues, sells, renews, or offers health insurance coverage in this state to comply with the Health Insurance Portability and Accountability Act[~~, P.L. 104-191, pursuant to 110 Stat. 1968, Sec. 2722~~].

Section 4. 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)[~~(b)~~](d) and notwithstanding Title 59, Chapter 9, Taxation of Admitted Insurers, [~~the fee provided for in this section constitutes the sole tax or fee~~] the following constitute the sole taxes, fees, or charges under the laws of this state that may be [~~otherwise~~] levied or assessed on a captive insurance company[~~, and no other occupation tax or other tax or fee may be levied or collected from a captive insurance company by the state or a county, city, or municipality within this state.~~]:

[~~(b) Notwithstanding Subsection (3)(a), a~~]

(i) a fee under this section;

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

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

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

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

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

(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by [~~March 31~~] June 20 of each year.

(5) (a) Money received pursuant to [~~Subsection (2)~~] 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 [~~imposed by the commissioner in accordance with this section~~] 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 [~~$600,000~~] $950,000 shall be treated as free revenue in the General Fund.

Section 5. Section **31A-14-211** is amended to read:

31A-14-211. Restrictions on foreign title insurers.

(1) An authorized foreign title insurer may not insure property in this state except:

(a) through a title insurance producer who is a resident in Utah; or

(b) through a bona fide [~~branch~~] office in Utah:

(i) that is under the direction and control of the authorized foreign title insurer [~~that pays all~~];

(ii) for which the authorized foreign title insurer pays the expenses [~~of the branch office~~], including compensation of [~~all~~] the employees[~~; or~~] of the bona fide office;

(iii) at which a person may request information about title services related to a real estate transaction for which the person is a party;

(iv) at which a person may deliver written communications to the authorized foreign title insurer as required by the real estate transaction for which the person is a party; and

(v) at which a person may deliver escrow money related to a real estate transaction for which the person is a party.

[~~(c) through a subsidiary title insurer authorized to do business in Utah.~~]

(2) This section does not apply to reinsurance.

Section 6. Section **31A-22-607** is amended to read:

31A-22-607. Grace period.

(1) [~~Every~~] (a) An individual or franchise accident and health insurance policy shall contain one or more clauses providing for a grace period for premium payment only of:

(i) at least 15 days for a weekly or monthly premium [~~policies~~] policy; and

(ii) 30 days for [~~all other policies~~] a policy that is not a weekly or monthly premium policy, for each premium after the first premium payment. [~~A carrier~~]

(b) An insurer may elect to include a grace period that is longer than 15 days for a weekly or monthly [~~policies~~] policy.

[~~(a) The~~] (c) An individual or franchise accident and health insurance policy is not in force during [~~the~~] a grace period.

[~~(b) If the~~] (d) If an insurer receives payment before [~~the~~] a grace period expires, the individual or franchise accident and health insurance policy continues in force with no gap in coverage.

[~~(c) If the~~] (e) If an insurer does not receive payment before [~~the~~] a grace period expires, the [~~policy shall be~~] individual or franchise accident and health insurance policy is terminated as of the last date for which the premium [~~was~~] is paid in full.

[~~(d)~~] (f) A grace period is not required if the policyholder has requested that the individual or franchise accident and health insurance policy be discontinued.

(2) [~~Every~~] (a) A group or blanket accident and health insurance policy shall provide for a grace period of at least 30 days, unless the policyholder gives written notice of discontinuance [~~prior to~~] before the date of discontinuance, in accordance with the policy terms. [~~In group or blanket policies, the~~]

(b) A group or blanket accident and health insurance policy is in force during a grace period.

(c) If an insurer does not receive payment before a grace period expires, the group or blanket accident and health insurance policy is terminated as of the last day of the grace period.

(d) A group or blanket accident and health insurance policy may provide for payment of a pro rata premium for the period the group or blanket accident and health insurance policy is in effect during [~~the~~] a grace period under this Subsection (2).

(3) If [~~the~~] an insurer has not guaranteed the insured a right to renew an accident and health insurance policy, [~~any~~] a grace period beyond the expiration or anniversary date may, if provided in the accident and health insurance policy, be cut off by compliance with the notice provision under Subsection 31A-21-303(4)(b).

Section 7. Section **31A-22-610.6** is amended to read:

31A-22-610.6. Special enrollment for individuals receiving premium assistance.

(1) As used in this section:

(a) "Premium assistance" means assistance under Title 26, Chapter 18, Medical Assistance Act, in the payment of premium.

(b) "Qualified beneficiary" means an individual who is approved to receive premium

assistance.

(2) Subject to the other provisions in this section, an individual may enroll under this section at a time outside of an employer health benefit plan open enrollment period, regardless of previously waiving coverage, if the individual is:

(a) a qualified beneficiary who is eligible for coverage as an employee under the employer health benefit plan; or

(b) a dependent of the qualified beneficiary who is eligible for coverage under the employer health benefit plan.

(3) To be eligible to enroll outside of an open enrollment period, an individual described in Subsection (2) shall enroll in the employer health benefit plan by no later than 30 days from the day on which the qualified beneficiary receives initial written notification, after July 1, 2008, that the qualified beneficiary is eligible to receive premium assistance.

(4) An individual described in Subsection (2) may enroll under this section only in an employer health benefit plan that is available at the time of enrollment to similarly situated eligible employees or dependents of eligible employees.

(5) Coverage under an employer health benefit plan for an individual described in Subsection (2) may begin as soon as the first day of the month immediately following enrollment of the individual in accordance with this section.

(6) This section does not modify any requirement related to premiums that applies under an employer health benefit plan to a similarly situated eligible employee or dependent of an eligible employee under the employer health benefit plan.

(7) An employer health benefit plan may require an individual described in Subsection (2) to satisfy a preexisting condition waiting period that:

(a) is allowed under the Health Insurance Portability and Accountability Act [~~of 1996, Pub. L. 104-191, 110 Stat. 1936~~]; and

(b) is not longer than 12 months.

Section 8. 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 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 [~~of 1996, Pub. L. 104-191, 110 Stat. 1936~~];

(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 [~~of 1996, Pub. L.~~

~~104-191, 110 Stat. 1936~~]; 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.

Section 9. Section **31A-22-625** is amended to read:

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

(1) As used in this section:

(a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden

on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, before reaching a maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b) (i) "50/50 mental health coverage" means coverage in a health benefit plan that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on:

(A) episodic limits;

(B) inpatient or outpatient service limits; or

(C) maximum out-of-pocket limits.

(c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(d) (i) "Mental health condition" means a condition or disorder involving mental illness that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) a marital or family problem;

(B) a social, occupational, religious, or other social maladjustment;

(C) a conduct disorder;

(D) a chronic adjustment disorder;

(E) a psychosexual disorder;

(F) a chronic organic brain syndrome;

(G) a personality disorder;

(H) a specific developmental disorder or learning disability; or

(I) mental retardation.

(e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(2) (a) At the time of purchase and renewal, an insurer shall offer to a small employer that it insures or seeks to insure a choice between catastrophic mental health coverage and 50/50 mental health coverage.

(b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, choose either catastrophic mental health coverage, 50/50 mental health coverage, or coverage offered under Subsection (2)(b), regardless of the employer's previous coverage for mental health conditions.

(d) An insurer is exempt from the 30% index rating restriction in Section 31A-30-106.1 and, for the first year only that catastrophic mental health coverage is chosen, the 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3) An insurer shall offer a large employer mental health and substance use disorder benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. [~~300gg-5~~] 300gg-26, and federal regulations adopted pursuant to that act.

(4) (a) An insurer may provide catastrophic mental health coverage to a small employer through a managed care organization or system in a manner consistent with Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the insurance policy uses a managed care organization or system for the treatment of physical health conditions.

(b) (i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.

(iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition must be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility:

(A) licensed or otherwise authorized to provide mental health services pursuant to:

(I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and

(B) that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may prohibit an insurance policy that provides mental health coverage in a manner that is inconsistent with this section.

(6) The commissioner shall:

(a) adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this section; and

(b) provide general figures on the percentage of insurance policies that include:

(i) no mental health coverage;

(ii) 50/50 mental health coverage;

(iii) catastrophic mental health coverage; and

(iv) coverage that exceeds the minimum requirements of this section.

(7) This section may not be construed as discouraging or otherwise preventing an insurer from providing mental health coverage in connection with an individual insurance policy.

(8) This section shall be repealed in accordance with Section 63I-1-231.

Section 10. 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 [~~or blanket~~] 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 [~~for a reason other than the purchase of insurance~~] 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) is formed and maintained in good faith for purposes other than obtaining insurance;

(iv) 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) 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; [~~and~~]

(vi) 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; [~~or~~] and

(vii) 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 [~~proposed~~] 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; [~~and~~]

(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 [~~also~~] be issued only to:

[~~(a)~~] (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 [~~their~~] the person's travel status;

[~~(b)~~] (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;

[~~(c)~~] (iii) an institution of learning, including a school district, a school jurisdictional [~~units~~] unit, or the head, principal, or governing board of [~~any of those units~~] a school jurisdictional unit, as policyholder, covering students, teachers, or employees;

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

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

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

[~~(g)~~] (vii) a newspaper or other publisher, as policyholder, covering its carriers;

[~~(h)~~] (viii) an association, including a labor union, [~~which~~] that has a constitution and bylaws and [~~which has been~~] that is organized in good faith for purposes other than that of obtaining insurance, as policyholder, covering [~~any~~] 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

[~~(i) a health insurance purchasing association, as defined in Section 31A-34-103, organized and controlled solely by participating employers; and~~]

[~~(j)~~] (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 11. Section **31A-22-716** is amended to read:

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

(1) Every 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 his 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[~~, P.L. No. 104-191, 110 Stat. 1960~~], all health benefit plans, health

insurers, and student health plans must provide a certificate of creditable coverage to each covered person upon the person's termination from the plan as soon as reasonably possible.

Section 12. Section **31A-22-721** is amended to read:

31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and nonrenewal.

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

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

(b) at the option of the plan sponsor.

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

(a) for a network plan, if:

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

(A) the service area of the insurer; or

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

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

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

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

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

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

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

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

(c) the plan sponsor:

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

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

(d) the insurer:

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

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

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

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

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

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

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any other health benefit products currently being offered:

(I) by the insurer in the market; or

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

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

(I) the claims experience of a plan sponsor;

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

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

(e) the insurer:

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

(A) in the small employer market; or

(B) the large employer market; or

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

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

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

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

(B) provides notice of the discontinuation in writing:

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

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

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

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

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

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

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new business in such market in this state for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(b) The commissioner may waive the prohibition under Subsection (8)(a) when the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(9) If an insurer is doing business in one established geographic service area of the state, this section applies only to the insurer's operations in that geographic service area.

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

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with a particular product or service.

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

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

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

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(12) (a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the small group market.

(b) A large employer that, after purchasing a health benefit plan in the large group market, employs on average less than 51 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the large group market.

(13) An insurer offering employer sponsored health benefit plans shall comply with the Health Insurance Portability and Accountability Act, [~~P. L. 104-191, 110 Stat. 1962, Sec. 2701~~

~~and 2702~~] 42 U.S.C. Sec. 300gg and 300gg-1.

Section 13. Section **31A-22-723** is amended to read:

31A-22-723. Conversion from group coverage.

(1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection (3), [~~all policies~~] a policy of accident and health insurance offered on a group basis under this title, or Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that a person whose insurance under the group policy has been terminated is entitled to choose a converted individual policy in accordance with this section and Section 31A-22-724.

(2) A person who has lost group coverage may elect conversion coverage with the insurer that provided prior group coverage if the person:

(a) has been continuously covered for a period of three months by the group policy or the group's preceding policies immediately prior to termination;

(b) has exhausted either:

(i) Utah mini-COBRA coverage as required in Section 31A-22-722;

(ii) federal COBRA coverage; or

(iii) alternative coverage under Section 31A-22-724;

(c) has not acquired or is not covered under any other group coverage that covers [~~all~~] preexisting conditions, including maternity, if the coverage exists; and

(d) resides in the insurer's service area.

(3) This section does not apply if the person's prior group coverage:

(a) is a stand alone policy that only provides one of the following:

(i) catastrophic benefits;

(ii) aggregate stop loss benefits;

(iii) specific stop loss benefits;

(iv) benefits for specific diseases;

(v) accidental injuries only;

(vi) dental; or

(vii) vision;

(b) is an income replacement policy;

(c) was terminated because the insured:

(i) failed to pay any required individual contribution;

(ii) performed an act or practice that constitutes fraud in connection with the coverage; or

(iii) made intentional misrepresentation of material fact under the terms of coverage; or

(d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or 31A-30-107(2)(a).

(4) (a) [~~The employer shall~~] An accident and health insurance policy offered on a group basis shall require the policyholder to provide written notification of the right to an individual conversion policy within 30 days of the insured's termination of coverage to:

(i) the terminated insured;

(ii) the ex-spouse; or

(iii) in the case of the death of the insured:

(A) the surviving spouse; and

(B) the guardian of any dependents, if different from a surviving spouse.

(b) The notification required by Subsection (4)(a) shall:

(i) be sent by first class mail;

(ii) contain the name, address, and telephone number of the insurer that will provide the conversion coverage; and

(iii) be sent to the insured's last-known address as shown on the records of the employer of:

(A) the insured;

(B) the ex-spouse; and

(C) if the policy terminates by reason of the death of the insured to:

(I) the surviving spouse; and

(II) the guardian of any dependents, if different from a surviving spouse.

(5) (a) An insurer is not required to issue a converted policy [~~which~~] that provides benefits in excess of those provided under the group policy from which conversion is made.

(b) Except as provided in Subsection (5)(c), if the conversion is made from a health benefit plan, the employee or member shall be offered[~~: (i) at least the basic benefit plan as provided in Section 31A-22-613.5 through December 31, 2009; and (ii) beginning January 1, 2010, only~~] the alternative coverage as provided in Subsection 31A-22-724(1)(a).

(c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels

provided under the group policy, the conversion policy may offer benefits [~~which~~] that are substantially similar to those provided under the group policy.

(6) Written application for [~~the~~] a converted policy shall be made and the first premium paid to the insurer no later than 60 days after termination of the group accident and health insurance.

(7) [~~The~~] A converted policy shall be issued without evidence of insurability.

(8) (a) The initial premium for the converted policy for the first 12 months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to age, class of risk of the person, and the type and amount of insurance provided.

(b) The initial premium for the first 12 months may not be raised based on pregnancy of a covered insured.

(c) The premium for converted policies shall be payable monthly or quarterly as required by the insurer for the policy form and plan selected, unless another mode or premium payment is mutually agreed upon.

(9) [~~The~~] A converted policy becomes effective at the time the insurance under the group policy terminates.

(10) (a) A newly issued converted policy covers the employee or the member and must also cover [~~all~~] dependents covered by the group policy at the date of termination of the group coverage.

(b) The only dependents that may be added after the policy has been issued are children and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).

(c) At the option of the insurer, a separate converted policy may be issued to cover [~~any~~] a dependent.

(11) (a) To the extent [~~the~~] a group policy provided maternity benefits, [~~the~~] a conversion policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group policy or the conversion policy until termination of a pregnancy that exists on the date of conversion if one of the following is pregnant on the date of the conversion:

(i) the insured;

(ii) a spouse of the insured; or

(iii) a dependent of the insured.

(b) [~~The requirements of this~~] This Subsection (11) [~~do~~] does not apply to a pregnancy

that occurs after the date of conversion.

(12) Except as provided in this Subsection (12), a converted policy is renewable with respect to [~~all individuals or dependents~~] an individual or dependent at the option of the insured. An insured may be terminated from a converted policy for the following reasons:

(a) a dependent is no longer eligible under the converted policy;

(b) for a network plan, if the individual no longer lives, resides, or works in:

(i) the insured's service area; or

(ii) the area for which the covered carrier is authorized to do business;

(c) the individual fails to pay premiums or contributions in accordance with the terms of the converted policy, including any timeliness requirements;

(d) the individual performs an act or practice that constitutes fraud in connection with the coverage;

(e) the individual makes an intentional misrepresentation of material fact under the terms of the coverage; or

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

(13) Conditions pertaining to health may not be used as a basis for classification under this section.

(14) An insurer is only required to offer a conversion policy that complies with Subsection 31A-22-724(1)(b) and, notwithstanding Sections 31A-8-402.5 and 31A-30-107.1, may discontinue any other conversion policy if:

(a) the discontinued conversion policy is discontinued uniformly without regard to [~~any~~] a health related factor;

(b) [~~any affected~~] an affected individual is provided with 90 days' advanced written notice of the discontinuation of the existing conversion policy;

(c) the [~~policy holder~~] policyholder is offered the insurer's conversion policy that complies with Subsection 31A-22-724(1)(b); and

(d) the [~~policy holder~~] policyholder is not re-rated for purposes of premium calculation.

(15) This section does not apply to a blanket accident and health insurance policy issued under Section 31A-22-701.

Section 14. Section **31A-23a-102** is amended to read:

31A-23a-102. Definitions.

As used in this chapter:

(1) "Bail bond producer" means a person who:

(a) is appointed by:

(i) a surety insurer that issues bail bonds; or

(ii) a bail bond surety company licensed under Chapter 35, Bail Bond Act;

(b) is designated to execute or countersign undertakings of bail in connection with a judicial proceeding; and

(c) receives or is promised money or other things of value for engaging in an act described in Subsection (1)(b).

(2) "Escrow" means a license subline of authority in conjunction with the title insurance line of authority that allows a person to conduct escrow as defined in Section 31A-1-301.

(3) "Home state" means a state or territory of the United States or the District of Columbia in which an insurance producer:

(a) maintains the insurance producer's principal:

(i) place of residence; or

(ii) place of business; and

(b) is licensed to act as an insurance producer.

(4) "Insurer" is as defined in Section 31A-1-301, except that the following persons or similar persons are not insurers for purposes of Part 7, Producer Controlled Insurers:

(a) a risk retention group as defined in:

(i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;

(ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and

(iii) Chapter 15, Part 2, Risk Retention Groups Act;

(b) a residual market pool;

(c) a joint underwriting authority or association; and

(d) a captive insurer.

(5) "License" is defined in Section 31A-1-301.

(6) (a) "Managing general agent" means a person that:

(i) manages all or part of the insurance business of an insurer, including the

management of a separate division, department, or underwriting office;

(ii) acts as an agent for the insurer whether it is known as a managing general agent, manager, or other similar term;

(iii) produces and underwrites an amount of gross direct written premium equal to, or more than 5% of, the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year:

(A) with or without the authority;

(B) separately or together with an affiliate; and

(C) directly or indirectly; and

(iv) (A) adjusts or pays claims in excess of an amount determined by the commissioner; or

(B) negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding Subsection (6)(a), the following persons may not be considered as managing general agent for the purposes of this chapter:

(i) an employee of the insurer;

(ii) a United States manager of the United States branch of an alien insurer;

(iii) an underwriting manager that, pursuant to contract:

(A) manages all the insurance operations of the insurer;

(B) is under common control with the insurer;

(C) is subject to Chapter 16, Insurance Holding Companies; and

(D) is not compensated based on the volume of premiums written; and

(iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

(7) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning a substantive benefit, term, or condition of the contract if the person engaged in that act:

(a) sells insurance; or

(b) obtains insurance from insurers for purchasers.

(8) "Reinsurance intermediary" means:

(a) a reinsurance intermediary-broker; or

(b) a reinsurance intermediary-manager.

(9) "Reinsurance intermediary-broker" means a person other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

(10) (a) "Reinsurance intermediary-manager" means a person who:

(i) has authority to bind or who manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office; and

(ii) acts as an agent for the reinsurer whether the person is known as a reinsurance intermediary-manager, manager, or other similar term.

(b) Notwithstanding Subsection (10)(a), the following persons may not be considered reinsurance intermediary-managers for the purpose of this chapter with respect to the reinsurer:

(i) an employee of the reinsurer;

(ii) a United States manager of the United States branch of an alien reinsurer;

(iii) an underwriting manager that, pursuant to contract:

(A) manages all the reinsurance operations of the reinsurer;

(B) is under common control with the reinsurer;

(C) is subject to Chapter 16, Insurance Holding Companies; and

(D) is not compensated based on the volume of premiums written; and

(iv) the manager of a group, association, pool, or organization of insurers that:

(A) engage in joint underwriting or joint reinsurance; and

(B) are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

(11) "Search" means a license subline of authority in conjunction with the title insurance line of authority that allows a person to issue title insurance commitments or policies on behalf of a title insurer.

(12) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

(13) "Solicit" means:

(a) attempting to sell insurance;

(b) asking or urging a person to apply for:

(i) a particular kind of insurance; and

(ii) insurance from a particular insurance company;

(c) advertising insurance, including advertising for the purpose of obtaining leads for the sale of insurance; or

(d) holding oneself out as being in the insurance business.

(14) "Terminate" means:

(a) the cancellation of the relationship between:

(i) an individual licensee or agency licensee and a particular insurer; or

(ii) an individual licensee and a particular agency licensee; or

(b) the termination of:

(i) an individual licensee's or agency licensee's authority to transact insurance on behalf of a particular insurance company; or

(ii) an individual licensee's authority to transact insurance on behalf of a particular agency licensee.

(15) "Title marketing representative" means a person who:

(a) represents a title insurer in soliciting, requesting, or negotiating the placing of:

(i) title insurance; or

(ii) escrow services; and

(b) does not have a search or escrow license as provided in Section 31A-23a-106.

(16) "Uniform application" means the version of the National Association of Insurance [~~Commissioner's~~] Commissioners' uniform application for resident and nonresident producer licensing at the time the application is filed.

(17) "Uniform business entity application" means the version of the National Association of Insurance [~~Commissioner's~~] Commissioners' uniform business entity application for resident and nonresident business entities at the time the application is filed.

Section 15. Section **31A-23a-106** is amended to read:

31A-23a-106. License types.

(1) (a) A resident or nonresident license issued under this chapter shall be issued under the license types described under Subsection (2).

(b) A license type and a line of authority pertaining to a license type describe the type of licensee and the lines of business that a licensee may sell, solicit, or negotiate. A license type is intended to describe the matters to be considered under any education, examination, and training required of a license applicant under Sections 31A-23a-108, 31A-23a-202, and 31A-23a-203.

(2) (a) A producer license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the producer has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond;

(vi) title insurance under one or more of the following categories:

(A) search, including authority to act as a title marketing representative;

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

(C) title marketing representative only;

(vii) personal lines insurance; and

(viii) surplus lines, if the producer has the property or casualty or both lines of authority.

(b) A limited line producer license type includes the following limited lines of authority:

(i) limited line credit insurance;

(ii) travel insurance;

(iii) motor club insurance;

(iv) car rental related insurance;

(v) legal expense insurance;

(vi) crop insurance;

(vii) self-service storage insurance; [~~and~~]

(viii) bail bond producer[~~.~~]; and

(ix) guaranteed asset protection waiver.

(c) A customer service representative license type includes the following lines of authority, if held by the customer service representative's employer producer:

(i) life insurance, including a nonvariable contract;

(ii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iii) property insurance;

(iv) casualty insurance, including a surety or other bond;

(v) personal lines insurance; and

(vi) surplus lines, if the employer producer has the property or casualty or both lines of authority.

(d) A consultant license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the consultant has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond; and

(vi) personal lines insurance.

(e) A managing general agent license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the managing general agent has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond; and

(vi) personal lines insurance.

(f) A reinsurance intermediary license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the reinsurance intermediary has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond; and

(vi) personal lines insurance.

(g) A [~~holder of licenses~~] person who holds a license under [~~Subsections~~] Subsection (2)(a), (d), (e), [~~and~~] or (f) has [~~all~~] the qualifications necessary to act as a holder of a license under Subsections (2)(b) and (c), except that the person may not act under Subsection (2)(b)(viii) or (ix).

(3) (a) The commissioner may by rule recognize other producer, limited line producer, customer service representative, consultant, managing general agent, or reinsurance intermediary lines of authority as to kinds of insurance not listed under Subsections (2)(a) through (f).

(b) Notwithstanding Subsection (3)(a), for purposes of title insurance the Title and Escrow Commission may by rule, with the concurrence of the commissioner and subject to Section 31A-2-404, recognize other categories for a title insurance producer line of authority not listed under Subsection (2)(a)(vi).

(4) The variable contracts, including variable life and annuity line of authority requires:

(a) licensure as a registered agent or broker by the [~~National Association of Securities Dealers~~] Financial Industry Regulatory Authority; and

(b) current registration with a securities broker-dealer.

(5) A surplus lines producer is a producer who has a surplus lines line of authority.

Section 16. Section **31A-23a-111** is amended to read:

31A-23a-111. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal or reinstatement.

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

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

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

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

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

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

(d) lapsed under Section 31A-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 [~~the~~] 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) the licensee dies or is adjudicated incompetent as defined under:

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

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

Minors;

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

(v) voluntarily surrendered.

(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.

(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 state's insurance department;

(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. [~~Secs.~~] Sec. 1033 and 1034; 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 17. Section **31A-23a-202** is amended to read:

31A-23a-202. Continuing education requirements.

(1) Pursuant to this section, the commissioner shall by rule prescribe the continuing

education requirements for a producer and a consultant.

(2) (a) The commissioner may not state a continuing education requirement in terms of formal education.

(b) The commissioner may state a continuing education requirement in terms of [~~classroom hours, or their equivalent,~~] hours of insurance-related instruction received.

(c) Insurance-related formal education may be a substitute, in whole or in part, for [~~classroom hours, or their equivalent,~~] the hours required under Subsection (2)(b).

(3) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (3).

(b) (i) Except as provided in this section, the continuing education requirements shall require:

(A) that a licensee complete 24 credit hours of continuing education for every two-year licensing period;

(B) that 3 of the 24 credit hours described in Subsection (3)(b)(i)(A) be ethics courses; and

(C) that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

(ii) [~~The hours not completed through classroom hours~~] An hour of continuing education in accordance with Subsection (3)(b)(i)[~~(C)~~] may be obtained through:

(A) classroom attendance;

[~~(A)~~] (B) home study;

[~~(B)~~] (C) watching a video recording;

[~~(C)~~] (D) experience credit; or

[~~(D)~~] (E) another method provided by rule.

(iii) (A) Notwithstanding Subsections (3)(b)(i)(A) and (B), a title insurance producer is required to complete 12 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses unless the title insurance producer is licensed in this state as a title insurance producer for 20 or more consecutive years.

(B) If a title insurance producer is licensed in this state as a title insurance producer for 20 or more consecutive years, the title insurance producer is required to complete 6 credit hours

of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses.

(C) Notwithstanding Subsection (3)(b)(iii)(A) or (B), a title insurance producer is considered to have met the continuing education requirements imposed under Subsection (3)(b)(iii)(A) or (B) if the title insurance producer:

(I) is an active member in good standing with the Utah State Bar;

(II) is in compliance with the continuing education requirements of the Utah State Bar; and

(III) if requested by the department, provides the department evidence that the title insurance producer complied with the continuing education requirements of the Utah State Bar.

(c) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(d) (i) A licensee is exempt from continuing education requirements under this section if:

(A) the licensee was first licensed before April 1, 1978;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before May 11, 2011;

[~~(B)~~] (C) the licensee requests an exemption from the department; and

[~~(C)~~] (D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (3)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall, by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(b);

(ii) authorize a continuing education provider or a state or national professional producer or consultant association to:

(A) offer a qualified program for a license type or line of authority on a geographically accessible basis; and

(B) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner; and

(iii) provide that membership by a producer or consultant in a state or national professional producer or consultant association is considered a substitute for the equivalent of two hours for each year during which the producer or consultant is a member of the professional association, except that the commissioner may not give more than two hours of continuing education credit in a year regardless of the number of professional associations of which the producer or consultant is a member.

(f) A fee permitted under Subsection (3)(e)(ii)(B) that is charged for attendance at a professional producer or consultant association program may be less for an association member, on the basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(4) The commissioner shall approve a continuing education provider or continuing education course that satisfies the requirements of this section.

(5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule set the processes and procedures for continuing education provider registration and course approval.

(6) The requirements of this section apply only to a producer or consultant who is an individual.

(7) A nonresident producer or consultant is considered to have satisfied this state's continuing education requirements if the nonresident producer or consultant satisfies the nonresident producer's or consultant's home state's continuing education requirements for a licensed insurance producer or consultant.

(8) A producer or consultant subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education applies.

Section 18. Section **31A-23a-203** is amended to read:

31A-23a-203. Training period requirements.

(1) A producer is eligible to add the surplus lines of authority to the person's producer's license if the producer:

(a) has passed the applicable examination;

(b) has been a producer with property and casualty 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).

[~~(3)~~] (4) The training periods required under this section apply only to an individual applying for a license under this chapter.

Section 19. Section **31A-23a-204** is amended to read:

31A-23a-204. Special requirements for title insurance producers and agencies.

A title insurance producer, including an agency, shall be licensed in accordance with this chapter, with the additional requirements listed in this section.

(1) (a) A person that receives a new license under this title as a title insurance agency, shall at the time of licensure be owned or managed by [~~one or more individuals who are~~] at least one individual who is licensed for at least three of the five years immediately [~~proceeding~~] preceding the date on which the title insurance agency applies for a license with both:

(i) a search line of authority; and

(ii) an escrow line of authority.

(b) A title insurance agency subject to Subsection (1)(a) may comply with Subsection (1)(a) by having the title insurance agency owned or managed by:

(i) one or more individuals who are licensed with the search line of authority for the time period provided in Subsection (1)(a); and

(ii) one or more individuals who are licensed with the escrow line of authority for the time period provided in Subsection (1)(a).

(c) A person licensed as a title insurance agency shall at all times during the term of licensure be owned or managed by at least one individual who is licensed for at least three years within the preceding five-year period with both:

(i) a search line of authority; and

(ii) an escrow line of authority.

[~~(c)~~] (d) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt an attorney with real estate experience from the experience requirements in Subsection (1)(a).

(2) (a) A title insurance agency or producer appointed by an insurer shall maintain:

(i) a fidelity bond;

(ii) a professional liability insurance policy; or

(iii) a financial protection:

(A) equivalent to that described in Subsection (2)(a)(i) or (ii); and

(B) that the commissioner considers adequate.

(b) The bond, insurance, or financial protection required by this Subsection (2):

(i) shall be supplied under a contract approved by the commissioner to provide protection against the improper performance of any service in conjunction with the issuance of a contract or policy of title insurance; and

(ii) be in a face amount no less than $50,000.

(c) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt title insurance producers from the requirements of this Subsection (2) upon a finding that, and only so long as, the required policy or bond is generally unavailable at reasonable rates.

(3) A title insurance agency or producer appointed by an insurer may maintain a reserve fund to the extent monies were deposited before July 1, 2008, and not withdrawn to the income of the title insurance producer.

(4) An examination for licensure shall include questions regarding the search and examination of title to real property.

(5) A title insurance producer may not perform the functions of escrow unless the title insurance producer has been examined on the fiduciary duties and procedures involved in those functions.

(6) The Title and Escrow Commission shall adopt rules, subject to Section 31A-2-404, after consulting with the department and the department's test administrator, establishing an examination for a license that will satisfy this section.

(7) A license may be issued to a title insurance producer who has qualified:

(a) to perform only searches and examinations of title as specified in Subsection (4);

(b) to handle only escrow arrangements as specified in Subsection (5); or

(c) to act as a title marketing representative.

(8) (a) A person licensed to practice law in Utah is exempt from the requirements of Subsections (2) and (3) if that person issues 12 or less policies in any 12-month period.

(b) In determining the number of policies issued by a person licensed to practice law in Utah for purposes of Subsection (8)(a), if the person licensed to practice law in Utah issues a policy to more than one party to the same closing, the person is considered to have issued only one policy.

(9) A person licensed to practice law in Utah, whether exempt under Subsection (8) or not, shall maintain a trust account separate from a law firm trust account for all title and real estate escrow transactions.

Section 20. Section **31A-23a-406** is amended to read:

31A-23a-406. Title insurance producer's business.

(1) A title insurance producer may do escrow involving real property transactions if all of the following exist:

(a) the title insurance producer is licensed with:

(i) the title line of authority; and

(ii) the escrow subline of authority;

(b) the title insurance producer is appointed by a title insurer authorized to do business in the state;

(c) the title insurance producer issues one or more of the following [~~is to be issued~~] as part of the transaction:

(i) an owner's policy of title insurance; or

(ii) a lender's policy of title insurance;

(d) [~~(i) all funds~~] money deposited with the title insurance producer in connection with any escrow:

[~~(A) are~~] (i) is deposited:

[~~(I)~~] (A) in a federally insured financial institution; and

[~~(II)~~] (B) in a trust account that is separate from all other trust account [~~funds that are~~] money that is not related to real estate transactions; [~~and~~]

[~~(B) are~~] (ii) is the property of the one or more persons entitled to [~~them~~] the money under the provisions of the escrow; and

[~~(ii) are~~] (iii) is segregated escrow by escrow in the records of the title insurance producer;

(e) earnings on [~~funds~~] money held in escrow may be paid out of the escrow account to any person in accordance with the conditions of the escrow; [~~and~~]

(f) the escrow does not require the title insurance producer to hold:

(i) construction [~~funds~~] money; or

(ii) [~~funds~~] money held for exchange under Section 1031, Internal Revenue Code[~~.~~]; and

(g) if the title insurance producer with an escrow subline of authority conducts a closing, the title insurance producer is physically present with a borrower, seller, or purchaser involving real estate that is the subject of the real estate transaction.

(2) Notwithstanding Subsection (1), a title insurance producer may engage in the escrow business if:

(a) the escrow involves:

(i) a mobile home;

(ii) a grazing right;

(iii) a water right; or

(iv) other personal property authorized by the commissioner; and

(b) the title insurance producer complies with [~~all the requirements of~~] this section except for [~~the requirement of~~] Subsection (1)(c).

(3) [~~Funds~~] Money held in escrow:

(a) [~~are~~] is not subject to any debts of the title insurance producer;

(b) may only be used to fulfill the terms of the individual escrow under which the [~~funds were~~] money is accepted; and

(c) may not be used until [~~all~~] the conditions of the escrow [~~have been~~] are met.

(4) Assets or property other than escrow [~~funds~~] money received by a title insurance producer in accordance with an escrow shall be maintained in a manner that will:

(a) reasonably preserve and protect the asset or property from loss, theft, or damages; and

(b) otherwise comply with [~~all~~] the general duties and responsibilities of a fiduciary or bailee.

(5) (a) A check from the trust account described in Subsection (1)(d) may not be drawn, executed, or dated, or [~~funds~~] money otherwise disbursed unless the segregated escrow account from which [~~funds are~~] money is to be disbursed contains a sufficient credit balance consisting of collected [~~or~~] and cleared [~~funds~~] money at the time the check is drawn, executed, or dated, or [~~funds are~~] money is otherwise disbursed.

(b) As used in this Subsection (5), [~~funds are~~] money is considered to be "collected [~~or~~] and cleared," and may be disbursed as follows:

(i) cash may be disbursed on the same day the cash is deposited;

(ii) a wire transfer may be disbursed on the same day the wire transfer is deposited; and

[~~(iii) the following may be disbursed on the day following the date of deposit:~~]

[~~(A) a cashier's check;~~]

[~~(B) a certified check;~~]

[~~(C) a teller's check;~~]

[~~(D) a U.S. Postal Service money order; and~~]

[~~(E) a check drawn on a Federal Reserve Bank or Federal Home Loan Bank; and~~]

[~~(iv) any other check or deposit may be disbursed:~~]

[~~(A) within the time limits provided under the Expedited Funds Availability Act, 12~~

~~U.S.C. Section 4001 et seq., as amended, and related regulations of the Federal Reserve System; or~~]

[~~(B) upon written notification from the financial institution to which the funds have been deposited, that final settlement has occurred on the deposited item.~~]

[~~(c) Subject to Subsections (5)(a) and (b), any material change to a settlement statement made after the final closing documents are executed must be authorized or acknowledged by date and signature on each page of the settlement statement by the one or more persons affected by the change before disbursement of funds.~~]

(iii) the proceeds of one or more of the following financial instruments may be disbursed on the same day the financial instruments are deposited if received from a single party to the real estate transaction and if the aggregate of the financial instruments for the real estate transaction is less than $10,000:

(A) a cashier's check, certified check, or official check that is drawn on an existing account at a federally insured financial institution;

(B) a check drawn on the trust account of a principal broker or associate broker licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the title producer has reasonable and prudent grounds to believe sufficient money will be available from the trust account on which the check is drawn at the time of disbursement of proceeds from the title producer's escrow account;

(C) a personal check not to exceed $500 per closing;

(D) a check drawn on the escrow account of another title producer, if the title producer in the escrow transaction has reasonable and prudent grounds to believe that sufficient money will be available for withdrawal from the account upon which the check is drawn at the time of disbursement of money from the escrow account of the title producer in the escrow transaction; or

(E) a check issued by a farm credit service authorized under the Farm Credit Act of 1971, 12 U.S.C. Sec. 2001 et seq., as amended.

(c) Money received from a financial instrument described in Subsection (5)(b)(iii)(B) or (C) may be disbursed:

(i) within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

(ii) upon notification from the financial institution to which the money has been deposited that final settlement has occurred on the deposited financial instrument.

(6) [~~The~~] A title insurance producer shall maintain [~~records of all receipts and disbursements of escrow funds~~] a record of a receipt or disbursement of escrow money.

(7) [~~The~~] A title insurance producer shall comply with:

(a) Section 31A-23a-409;

(b) Title 46, Chapter 1, Notaries Public Reform Act; and

(c) any rules adopted by the Title and Escrow Commission, subject to Section 31A-2-404, that govern escrows.

(8) If a title insurance producer conducts a search for real estate located in the state, the title insurance producer shall conduct a minimum mandatory search, as defined by rule made by the Title and Escrow Commission, subject to Section 31A-2-404.

Section 21. Section **31A-23a-408** is amended to read:

31A-23a-408. Representations of agency.

[~~No~~] A person may not represent [~~himself as~~] that the person is acting in behalf of an insurer unless a written agency contract is in effect giving the person authority from the insurer and the insurer [~~has appointed~~] appoints that person to act in behalf of the insurer.

Section 22. Section **31A-23a-412** is amended to read:

31A-23a-412. Place of business and residence address -- Records.

(1) (a) [~~All licensees~~] A licensee under this chapter shall register and maintain with the commissioner:

(i) the address and telephone numbers of [~~their~~] the licensee's principal place of business[~~.~~]; and

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

(b) If [~~the~~] a licensee is an individual, in addition to complying with Subsection (1)(a) the individual shall [~~provide to~~] 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 [~~any~~] a change of any of the following required to be registered with the commissioner under this section:

(i) an address [~~or~~];

(ii) a telephone number[~~.~~]; or

(iii) a business email address.

(2) (a) Except as provided under Subsection (3), [~~every~~] 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 [~~all~~] 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, 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, 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 [~~all~~] 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.

(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 all 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 23. Section **31A-25-208** is amended to read:

31A-25-208. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal and reinstatement.

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

(a) revoked or suspended under Subsection (4);

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

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

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

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

(d) lapsed under Section 31A-25-210; or

(e) voluntarily surrendered.

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

(a) a lapsed license; or

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

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

(a) this title; or

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

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

commissioner may:

(i) revoke a license;

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

(iii) limit a license in whole or in part; or

(iv) deny a license application.

(b) The commissioner may take an action described in Subsection (4)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license under Section 31A-25-202, 31A-25-203, or 31A-25-204;

(ii) has violated:

(A) an insurance statute;

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

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

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

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

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

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

(vii) refuses:

(A) to be examined; or

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

(viii) has an officer who refuses to:

(A) give information with respect to the third party administrator's affairs; or

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

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

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) has violated an insurance law, valid rule, or valid order of another state's insurance department;

(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

(xii) has improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

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

(A) insurance contract; or

(B) application for insurance;

(xiv) has been convicted of a felony;

(xv) has admitted or been found to have committed an insurance unfair trade practice or fraud;

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

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

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

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

(xviii) has forged another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;

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

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

(xxii) has failed to:

(A) pay state income tax; or

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

(xxiii) has violated or permitted others to violate the federal Violent Crime Control and

Law Enforcement Act of 1994, 18 U.S.C. [~~Secs.~~] Sec. 1033 and 1034; or

(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.

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

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

(i) the individual;

(ii) the agency if the agency:

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

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

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

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

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

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

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

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

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

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in the order or agreement described in Subsection (7)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval of the commissioner.

(8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by the court.

(9) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 24. Section **31A-26-206** is amended to read:

31A-26-206. Continuing education requirements.

(1) Pursuant to this section, the commissioner shall by rule prescribe continuing education requirements for each class of license under Section 31A-26-204.

(2) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (2).

(b) (i) Except as otherwise provided in [~~Subsection (2)(b)(iii)~~] this section, the continuing education requirements shall require:

(A) that a licensee complete 24 credit hours of continuing education for every two-year licensing period;

(B) that [~~three~~] 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses; and

(C) that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

[~~(ii) The hours not completed through classroom hours~~]

(ii) A continuing education hour completed in accordance with Subsection (2)(b)(i)[~~(C)~~] may be obtained through:

(A) classroom attendance;

[~~(A)~~] (B) home study;

[~~(B)~~] (C) watching a video recording;

[~~(C)~~] (D) experience credit; or

[~~(D)~~] (E) other methods provided by rule.

(iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is required to complete 12 credit hours of continuing education for every two-year licensing period, with [~~three~~] 3 of the credit hours being ethics courses.

(c) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(d) (i) [~~Beginning May 3, 1999, a~~] A licensee is exempt from the continuing education requirements of this section if:

(A) the licensee was first licensed before April 1, [~~1970~~] 1978;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before May 11, 2011;

[~~(B)~~] (C) the licensee requests an exemption from the department; and

[~~(C)~~] (D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (2)(b); and

(ii) authorize a professional adjuster [~~associations~~] association to:

(A) offer a qualified [~~programs for all classes of licenses~~] program for a classification of license on a geographically accessible basis; and

(B) collect a reasonable [~~fees~~] fee for funding and administration of [~~the continuing education programs~~] a qualified program, subject to the review and approval of the commissioner.

(f) (i) [~~The fees~~] A fee permitted under Subsection (2)(e)(ii)(B) that [~~are~~] is charged to fund and administer a qualified program shall reasonably relate to the [~~costs~~] cost of administering the qualified program.

(ii) Nothing in this section shall prohibit a provider of a continuing education [~~programs or courses~~] program or course from charging [~~fees~~] a fee for attendance at [~~courses~~] a course offered for continuing education credit.

(iii) [~~The fees~~] A fee permitted under Subsection (2)(e)(ii)(B) that [~~are~~] is charged for attendance at an association program may be less for an association member, [~~based~~] on the basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(3) The continuing education requirements of this section apply only to [~~licensees who are natural persons~~] a licensee who is an individual.

(4) The continuing education requirements of this section do not apply to [~~members~~] a member of the Utah State Bar.

(5) The commissioner shall designate [~~courses that satisfy~~] a course that satisfies the requirements of this section, including [~~those~~] a course presented by [~~insurers~~] an insurer.

(6) A nonresident adjuster is considered to have satisfied this state's continuing education requirements if:

(a) the nonresident adjuster satisfies the nonresident producer's home state's continuing education requirements for a licensed insurance adjuster; and

(b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's continuing education requirements for a producer as satisfying the continuing education requirements of the home state.

(7) A licensee subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education requirement applies.

Section 25. Section **31A-26-208** is amended to read:

31A-26-208. Nonresident jurisdictional agreement.

(1) (a) If a nonresident license applicant has a valid license from the nonresident license applicant's home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive any license requirement for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident adjuster's license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed as a resident in the nonresident license applicant's home state at the time the nonresident license applicant applies for a nonresident adjuster license;

(B) has submitted the proper request for licensure;

(C) has submitted to the commissioner:

(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state; or

(II) a completed uniform application; and

(D) has paid the applicable fees under Section 31A-3-103;

(ii) the nonresident license applicant's license in the applicant's home state is in good standing; and

(iii) the nonresident license applicant's home state awards nonresident adjuster licenses to residents of this state on the same basis as this state awards licenses to residents of that home state.

(2) A nonresident applicant shall execute in a form acceptable to the commissioner an agreement to be subject to the jurisdiction of the commissioner and courts of this state on any matter related to the adjuster's insurance activities in this state, on the basis of:

(a) service of process under Sections 31A-2-309 and 31A-2-310; or

(b) other service authorized under the Utah Rules of Civil Procedure or Section 78B-3-206.

(3) The commissioner may verify [~~the third party administrator's~~] an adjuster's licensing status through the database maintained by:

(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state based solely on the fact that the person does not reside in this state.

Section 26. Section **31A-26-213** is amended to read:

31A-26-213. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal or reinstatement.

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

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

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

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

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

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

(d) lapsed under Section 31A-26-214.5; or

(e) voluntarily surrendered.

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

(a) a lapsed license; or

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

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

(a) this title; or

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

(4) A license classification issued under this chapter remains in force until:

(a) the qualifications pertaining to a license classification are no longer met by the licensee; or

(b) the supporting license type:

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

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

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

(i) revoke:

(A) a license; or

(B) a license classification;

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

(A) a license; or

(B) a license classification;

(iii) limit in whole or in part:

(A) a license; or

(B) a license classification; or

(iv) deny a license application.

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

(i) is unqualified for a license or license classification under Section 31A-26-202, 31A-26-203, 31A-26-204, or 31A-26-205;

(ii) has violated:

(A) an insurance statute;

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

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

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

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

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

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

(vii) refuses:

(A) to be examined; or

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

(viii) has an officer who refuses to:

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

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

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

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) has violated an insurance law, valid rule, or valid order of another state's insurance department;

(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

(xii) has improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

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

(A) insurance contract; or

(B) application for insurance;

(xiv) has been convicted of a felony;

(xv) has admitted or been found to have committed an insurance unfair trade practice or fraud;

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

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

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

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

(xviii) has forged another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;

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

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

(xxii) has failed to:

(A) pay state income tax; or

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

(xxiii) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. [~~Secs.~~] Sec. 1033 and 1034; 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 27. Section **31A-26-306** is amended to read:

31A-26-306. Place of business -- Records.

(1) (a) An insurance adjuster licensed under this chapter shall[~~: (i)~~] register and maintain with the commissioner:

(i) the address and telephone number of the licensee's principal place of business; [~~and~~]

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

[~~(ii)~~] (iii) if the licensee is an individual, [~~provide~~] the licensee's residence address and telephone number.

(b) A licensee shall notify the commissioner within 30 days of [~~any change of~~] a change in one of the following required to be registered under Subsection (1)(a):

(i) an address [~~or~~];

(ii) a telephone number[~~.~~]; or

(iii) a business email address.

(2) Except as provided under Subsection (3), [~~every~~] an insurance adjuster shall keep at the address registered under Subsection (1), a record of [~~all~~] the transactions consummated under the insurance adjuster's license, including a record of:

(a) each investigation or adjustment undertaken or consummated; and

(b) [~~any~~] a fee, commission, or other compensation received or to be received by the adjuster on account of the investigation or adjustment.

(3) Subsection (2) is satisfied if the records specified in [~~that subsection~~] Subsection (2) can be obtained immediately from a central storage place elsewhere by on-line computer terminals located at the registered address.

(4) (a) [~~The records~~] A record maintained as to a transaction under Subsection (2) shall be kept available for the inspection of the commissioner during all business hours for a period of time after the date of the transaction specified by the commissioner by rule, but in no case for less than the current calendar year plus three years.

(b) Discarding [~~records~~] a record after the then applicable record retention period is passed does not place the licensee in violation of a later-adopted longer record retention period.

Section 28. Section **31A-28-107** is amended to read:

31A-28-107. Board of directors.

(1) (a) The board of directors of the association shall consist of:

(i) at least five but not more than nine member insurers who:

(A) subject to Subsection (1)(e), serve terms as established in the plan of operation; and

(B) are selected by member insurers, subject to the approval of the commissioner; and

(ii) two public representatives appointed by the commissioner.

(b) (i) The commissioner shall make the appointment of a public representative coincide with the association's annual meeting at which the association's board of directors is elected.

(ii) A public representative may not be:

(A) an officer, director, or employee of an insurer; or

(B) a person engaged in the business of insurance.

(iii) Subject to Subsection (1)(e), a public representative shall serve a term of three years.

(c) When a vacancy occurs in the membership of the board of directors for any reason:

(i) if the vacancy is of a member insurer, a replacement may be elected for the unexpired term by a majority vote of the remaining board members, subject to the approval of the commissioner; and

(ii) if the vacancy is of a public representative, the commissioner shall appoint a replacement for the unexpired term.

(d) In approving a selection or in appointing a member to the board of directors, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(e) Notwithstanding Subsections (1)(a) and (b), the commissioner shall, at the time of election, reelection, 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 of directors is selected during any two-year period.

(2) (a) A member of the board of directors may be reimbursed from the assets of the association for expenses incurred by the member as a member of the board of directors.

(b) A public representative appointed under Subsection (1)(a)(ii) may not receive compensation or benefits for the public representative's service, but in addition to reimbursement under Subsection (2)(a), a public representative may receive per diem and

travel expenses established by the board with the approval of the commissioner.

[~~(b)~~] (c) Except as provided in [~~Subsection (2)(a)~~] Subsections (2)(a) and (b), a member of the board of directors may not be compensated by the association for the member's services.

Section 29. Section **31A-29-103** is amended to read:

31A-29-103. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the pool created in Section 31A-29-104.

(2) (a) "Creditable coverage" has the same meaning as provided in Section 31A-1-301.

(b) "Creditable coverage" does not include a period of time in which there is a significant break in coverage, as defined in Section 31A-1-301.

(3) "Domicile" means the place where an individual has a fixed and permanent home and principal establishment:

(a) to which the individual, if absent, intends to return; and

(b) in which the individual, and the individual's family voluntarily reside, not for a special or temporary purpose, but with the intention of making a permanent home.

(4) "Enrollee" means an individual who has met the eligibility requirements of the pool and is covered by a pool policy under this chapter.

(5) "Health benefit plan":

(a) is defined in Section 31A-1-301; and

(b) does not include a plan that:

(i) (A) has a maximum actuarial value less that 100% of the basic health care plan; or

(B) has a maximum annual limit of $100,000 or less; and

(ii) meets other criteria established by the board.

(6) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(7) "Health care insurance" is defined in Section 31A-1-301.

(8) "Health care provider" has the same meaning as provided in Section 78B-3-403.

(9) "Health care services" means:

(a) any service or product:

(i) used in furnishing to any individual medical care or hospitalization; or

(ii) incidental to furnishing medical care or hospitalization; and

(b) any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(10) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

(11) "Health plan" means any arrangement by which an individual, including a dependent or spouse, covered or making application to be covered under the pool has:

(a) access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract;

(b) coverage through:

(i) a health maintenance organization;

(ii) a preferred provider prepayment;

(iii) group practice;

(iv) individual practice plan; or

(v) health care insurance;

(c) coverage under an uninsured arrangement of group or group-type contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance;

(d) coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and

(e) coverage by Medicare or other governmental benefit.

(12) "HIPAA" means the Health Insurance Portability and Accountability Act [~~of 1996, Pub. L. 104-191, 110 Stat. 1936~~].

(13) "HIPAA eligible" means an individual who is eligible under the provisions of the Health Insurance Portability and Accountability Act [~~of 1996, Pub. L. 104-191, 110 Stat. 1936~~].

(14) "Insurer" means:

(a) an insurance company authorized to transact accident and health insurance business in this state;

(b) a health maintenance organization; or

(c) a self-insurer not subject to federal preemption.

(15) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., as amended.

(16) "Medicare" means coverage under both Part A and B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 et seq., as amended.

(17) "Plan of operation" means the plan developed by the board in accordance with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board under Section 31A-29-106.

(18) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section 31A-29-104.

(19) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund created in Section 31A-29-120.

(20) "Pool policy" means a health benefit plan policy issued under this chapter.

(21) "Preexisting condition" has the same meaning as defined in Section 31A-1-301.

(22) (a) "Resident" or "residency" means a person who is domiciled in this state.

(b) A resident retains residency if that resident leaves this state:

(i) to serve in the armed forces of the United States; or

(ii) for religious or educational purposes.

(23) "Third-party administrator" has the same meaning as provided in Section 31A-1-301.

Section 30. Section **31A-29-106** is amended to read:

31A-29-106. Powers of board.

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health care insurance business. In addition, the board shall have the specific authority to:

(a) enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:

(i) similar pools of other states for the joint performance of common administrative functions; or

(ii) persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking such legal action necessary to avoid the payment of improper claims against the pool or the coverage provided through the pool;

(c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;

(d) issue policies of insurance in accordance with the requirements of this chapter;

(e) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool;

(f) establish rules, conditions, and procedures for reinsuring risks under this chapter;

(g) cause the pool to have an annual audit of its operations by the state auditor;

(h) coordinate with the Department of Health in seeking to obtain from the Centers for Medicare and Medicaid Services, or other appropriate office or agency of government, all appropriate waivers, authority, and permission needed to coordinate the coverage available from the pool with coverage available under Medicaid, either before or after Medicaid coverage, or as a conversion option upon completion of Medicaid eligibility, without the necessity for requalification by the enrollee;

(i) provide for and employ cost containment measures and requirements including preadmission certification, concurrent inpatient review, and individual case management for the purpose of making the pool more cost-effective;

(j) offer pool coverage through contracts with health maintenance organizations, preferred provider organizations, and other managed care systems that will manage costs while maintaining quality care;

(k) establish annual limits on benefits payable under the pool to or on behalf of any enrollee;

(l) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;

(m) administer the Pool Fund;

(n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this chapter; and

(o) adopt, trademark, and copyright a trade name for the pool for use in marketing and publicizing the pool and its products.

(2) (a) The board shall prepare and submit an annual report to the Legislature which shall include:

(i) the net premiums anticipated;

(ii) actuarial projections of payments required of the pool;

(iii) the expenses of administration; and

(iv) the anticipated reserves or losses of the pool.

(b) The budget for operation of the pool is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

(3) (a) The board shall on or before September 1, 2004, require the plan administrator or an independent actuarial consultant retained by the plan administrator to redetermine the reasonable equivalent of the criteria for uninsurability required under Subsection 31A-30-106(1)[~~(j)~~](h) that is used by the board to determine eligibility for coverage in the pool.

(b) The board shall redetermine the criteria established in Subsection (3)(a) at least every five years thereafter.

Section 31. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with [~~Section~~] Sections 31A-30-106 and 31A-30-106.1, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) "Basic benefit plan" or "basic coverage" means the coverage provided in the Basic

Health Care Plan under Section 31A-22-613.5.

(5) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the [~~department~~] commissioner in accordance with Section 31A-30-105.

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this chapter.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.

(11) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(12) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(13) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(16) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.

(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Premium" means [~~all~~] money paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

(21) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(22) "Resident" means an individual who has resided in this state for at least 12

consecutive months immediately preceding the date of application.

(23) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

(24) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

(25) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)[~~(i) and (j)~~](g) and (h) for which coverage the applicant is applying.

(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and

(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.

Section 32. Section **31A-30-105** is amended to read:

31A-30-105. Establishment of classes of business.

(1) For [~~policies that go into~~] a policy that takes effect on or after January 1, 2011, a covered carrier may not establish a separate class of business unless:

(a) the covered carrier submits an application to the [~~department~~] commissioner to establish a separate class of business;

(b) the covered carrier demonstrates to the satisfaction of the [~~department~~] commissioner that a separate class of business is justified under the provisions of this section; and

(c) the [~~department~~] commissioner approves the carrier's application for the use of a separate class of business.

(2) (a) The [~~presumption of the department shall be~~] commissioner shall have a presumption against the use of a separate class of business by a covered insured, except when the covered carrier demonstrates that [~~the provisions of~~] this Subsection (2) [~~apply~~] applies.

(b) The [~~department~~] commissioner may approve the use of a separate class of business only if the covered carrier can demonstrate that the use of a separate class of business is necessary due to substantial differences in either expected claims experience or administrative costs related to the following reasons:

(i) the covered carrier uses more than one type of system for the marketing and sale of health benefit plans to covered insureds;

(ii) the covered carrier has acquired a class of business from another covered carrier; or

(iii) the covered carrier provides coverage to one or more association groups.

(3) The commissioner may establish regulations to provide for a period of transition in order for a covered carrier to come into compliance with Subsection (2) in the instance of acquisition of an additional class of business from another covered carrier.

(4) The commissioner may approve the establishment of up to five classes of business per covered carrier upon application to the commissioner and a finding by the commissioner that such action would substantially enhance the efficiency and fairness of the health insurance marketplace subject to this chapter.

(5) A covered carrier may not establish a class of business based solely on the marketing or sale of a health benefit plan as a defined contribution arrangement health benefit plan, or through the Health Insurance Exchange.

Section 33. 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 [~~the provisions of~~] 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 [~~provided in Section 31A-30-106.1~~] except as provided under Subsection (1)(b)(ii).

(ii) A carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan.

(d) (i) A carrier offering an individual health benefit plan shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical individuals that:

(A) differ only by the amounts attributable to plan design; and

(B) do not reflect differences due to the nature of the individuals assumed to select particular health benefit products.

(iii) A carrier offering an individual health benefit plan shall treat all health benefit

plans issued or renewed in the same calendar month as having the same rating period.

(e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(f) A carrier offering a health benefit plan to an individual may not, without prior approval of the commissioner, use case characteristics other than:

(i) age;

(ii) gender;

(iii) geographic area; and

(iv) family composition.

(g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(A) implement this chapter; and

(B) assure that rating practices used by carriers who offer health benefit plans to individuals are consistent with the purposes of this chapter.

(ii) The rules described in Subsection (1)(g)(i) may include rules that:

(A) assure that differences in rates charged for health benefit products by carriers who offer health benefit plans to individuals are reasonable and reflect objective differences in plan design, not including differences due to the nature of the individuals assumed to select particular health benefit products;

(B) prescribe the manner in which case characteristics may be used by carriers who offer health benefit plans to individuals;

(C) implement the individual enrollment cap under Section 31A-30-110, including specifying:

(I) the contents for certification;

(II) auditing standards;

(III) underwriting criteria for uninsurable classification; and

(IV) limitations on high risk enrollees under Section 31A-30-111; and

(D) establish the individual enrollment cap under Subsection 31A-30-110(1).

(h) Before implementing regulations for underwriting criteria for uninsurable

classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 325% of that expected for a standard insurable individual with the same case characteristics.

(i) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the covered carrier is actively enrolling new covered insureds.

(3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard to:

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b) (i) Each carrier subject to this section shall file with the commissioner, on or before April 1 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the carrier is in compliance with this chapter; and

(B) the rating methods of the carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the carrier at the carrier's principal place of business.

(c) A carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) Records 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 34. 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 [~~the provisions of~~] this section for a health benefit plan that is issued or renewed, on or after January 1, 2011.

(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.

(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 <u>of the employee</u>, as determined at the beginning of the plan year, limited to:

(i) the following age bands:

(A) less than 20;

(B) 20-24;

(C) 25-29;

(D) 30-34;

(E) 35-39;

(F) 40-44;

(G) 45-49;

(H) 50-54;

(I) 55-59;

(J) 60-64; and

(K) 65 and above; and

(ii) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection (6)(c):

(A) as developed by the [~~department~~] commissioner by administrative rule;

(B) not to exceed an overall ratio of 5:1; and

(C) the age slope ratios for each age band may not overlap;

(b) geographic area; and

(c) family composition, limited to:

(i) an overall ratio of 5:1 or less; and

(ii) a four tier rating structure that includes:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a dependent or dependents; and

(D) a family, consisting of an employee plus spouse, and a dependent or dependents.

(7) 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 into which the small employer carrier is actively enrolling new covered insureds.

(8) (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.

(9) (a) Each 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 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 (9)(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 (9) available to the commissioner upon request.

(10) (a) The commissioner shall, by July 1, 2010, 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, [~~as effective~~] in effect on January 1, 2011, 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.

(11) 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 35. Section **31A-30-106.5** is amended to read:

31A-30-106.5. Conversion policy -- Premiums -- Rating restrictions.

(1) [~~All provisions of Section 31A-30-106.1 apply~~] Section 31A-30-106 applies to

conversion policies.

(2) Conversion policy premium rates may not exceed by more than 35% the index rate for [~~small employers~~] individuals with similar case characteristics for any class of business in which the policy form has been [~~approved~~] filed.

(3) An insurer may not consider pregnancy of a covered insured in determining its conversion policy premium rates.

Section 36. Section **31A-30-108** is amended to read:

31A-30-108. Eligibility for small employer and individual market.

(1) (a) Small employer carriers shall accept residents for small group coverage as set forth in the Health Insurance Portability and Accountability Act, [~~P.L. 104-191, 110 Stat. 1962,~~] Sec. 2701(f) and 2711(a).

(b) Individual carriers shall accept residents for individual coverage pursuant to:

(i) [~~to P.L. 104-191, 110 Stat. 1979~~] Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and

(ii) Subsection (3).

(2) (a) Small employer carriers shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.

(b) Small employer carriers may:

(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:

(a) the individual is not covered or eligible for coverage:

(i) (A) as an employee of an employer;

(B) as a member of an association; or

(C) as a member of any other group; and

(ii) under:

(A) a health benefit plan; or

(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;

(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:

(i) the Medicare program established under Title XVIII of the Social Security Act;

(ii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or

(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;

(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:

(i) Medicare supplement policy;

(ii) conversion option;

(iii) continuation or extension under COBRA; or

(iv) state extension;

(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under [~~P.L. 104-191, 110 Stat. 1979~~] Health Insurance Portability and Accountability Act, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and

(e) the individual is certified as ineligible for the Health Insurance Pool if:

(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111(5)(c); or

(ii) the individual applies for coverage with any individual carrier within 45 days after:

(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or

(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.

(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is

paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.

(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:

(i) cancellation of coverage under Subsection 31A-29-115(1); or

(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.

(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.

(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:

(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and

(ii) the commissioner finds that the carrier's issuance of new individual policies:

(A) is in the best interests of the state; and

(B) does not provide an unfair advantage to the carrier.

(6) (a) If the Comprehensive Health Insurance Pool, as set forth under [~~Title 31A~~], Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in [~~P.L. 104-191, 110 Stat. 1979~~] Health Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).

(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the [~~Utah Insurance Department~~] department.

(7) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:

(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and

(ii) within the service area of the network plan, deny coverage to an employer if the

small employer carrier has demonstrated to the commissioner that the small employer carrier:

(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and

(B) applies this section uniformly to all employers without regard to:

(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or

(II) any health status-related factor relating to an employee or dependent of an employee.

(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.

(ii) This Subsection (7)(b) does not:

(A) limit the small employer carrier's ability to renew coverage that is in force; or

(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.

(c) Coverage offered within a service area after the 180-day period specified in Subsection (7)(b) is subject to the requirements of this section.

Section 37. Section **31A-30-110** is amended to read:

31A-30-110. Individual enrollment cap.

(1) The commissioner shall set the individual enrollment cap at .5% on July 1, 1997.

(2) The commissioner shall raise the individual enrollment cap by .5% at the later of the following dates:

(a) six months from the last increase in the individual enrollment cap; or

(b) the date when CCI/TI is greater than .90, where:

(i) "CCI" is the total individual coverage count for all carriers certifying that their uninsurable percentage has reached the individual enrollment cap; and

(ii) "TI" is the total individual coverage count for all carriers.

(3) The commissioner may establish a minimum number of uninsurable individuals that a carrier entering the market who is subject to this chapter must accept under the individual

enrollment provisions of this chapter.

(4) Beginning July 1, 1997, an individual carrier may decline to accept individuals applying for individual enrollment under Subsection 31A-30-108(3), other than individuals applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b), if:

(a) the uninsurable percentage for that carrier equals or exceeds the cap established in Subsection (1); and

(b) the covered carrier has certified on forms provided by the commissioner that its uninsurable percentage equals or exceeds the individual enrollment cap.

(5) The department may audit a carrier's records to verify whether the carrier's uninsurable classification meets industry standards for underwriting criteria as established by the commissioner in accordance with Subsection 31A-30-106(1)[~~(i)~~](h).

(6) (a) If the commissioner determines that individual enrollment is causing a substantial adverse effect on premiums, enrollment, or experience, the commissioner may suspend, limit, or delay further individual enrollment for up to 12 months.

(b) The commissioner shall adopt rules to establish a uniform methodology for calculating and reporting loss ratios for individual policies for determining whether the individual enrollment provisions of Section 31A-30-108 should be waived for an individual carrier experiencing significant and adverse financial impact as a result of complying with those provisions.

Section 38. Section **31A-30-112** is amended to read:

31A-30-112. Employee participation levels.

(1) (a) Except as provided in Subsection (2) and Section 31A-30-206, a requirement used by a covered carrier in determining whether to provide coverage to a small employer, including a requirement for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the covered carrier.

(b) In addition to applying Subsection 31A-1-301[~~(121)~~](123), a covered carrier may require that a small employer have a minimum of two eligible employees to meet participation requirements.

(2) A covered carrier may not increase a requirement for minimum employee

participation or a requirement for minimum employer contribution applicable to a small employer at any time after the small employer is accepted for coverage.

Section 39. Section **31A-31-108** is amended to read:

31A-31-108. Assessment of insurers.

(1) For purposes of this section:

(a) The commissioner shall by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, define:

(i) "annuity consideration";

(ii) "membership fees";

(iii) "other fees";

(iv) "deposit-type contract funds"; and

(v) "other considerations in Utah."

(b) "Utah consideration" means:

(i) the total premiums written for Utah risks;

(ii) annuity consideration;

(iii) membership fees collected by the insurer;

(iv) other fees collected by the insurer;

(v) deposit-type contract funds; and

(vi) other considerations in Utah.

(c) "Utah risks" means insurance coverage on the lives, health, or against the liability of persons residing in Utah, or on property located in Utah, other than property temporarily in transit through Utah.

(2) To implement this chapter, Section 34A-2-110, and Section 76-6-521, the commissioner may assess each admitted insurer and each nonadmitted insurer transacting insurance under Chapter 15, Parts 1, Unauthorized Insurers and Surplus Lines, and 2, [~~Unauthorized Insurers~~] Risk Retention Groups Act, an annual fee as follows:

(a) $150 for an insurer, if the sum of the Utah consideration for that insurer is less than or equal to $1,000,000;

(b) $400 for an insurer, if the sum of the Utah consideration for that insurer is greater than $1,000,000 but is less than or equal to $2,500,000;

(c) $700 for an insurer, if the sum of the Utah consideration for that insurer is greater

than $2,500,000 but is less than or equal to $5,000,000;

(d) $1,350 for an insurer, if the sum of the Utah consideration for that insurer is greater than $5,000,000 but less than or equal to $10,000,000;

(e) $5,150 for an insurer, if the sum of the Utah consideration for that insurer is greater than $10,000,000 but less than $50,000,000; and

(f) $12,350 for an insurer, if the sum of the Utah consideration for that insurer equals or exceeds $50,000,000.

(3) [~~All money~~] Money received by the state under this section shall be deposited [~~in the General Fund as a dedicated credit of the department for the purpose of providing funds to pay for any costs and expenses incurred by the department in the administration, investigation, and enforcement of this chapter, Section 34A-2-110, and Section 76-6-521.~~] into the Insurance Fraud Investigation Restricted Account created in Subsection (4).

(4) (a) There is created in the General Fund a restricted account known as the "Insurance Fraud Investigation Restricted Account."

(b) The Insurance Fraud Investigation Restricted Account shall consist of the money received by the commissioner under this section and Section 31A-31-109.

(c) The commissioner shall administer the Insurance Fraud Investigation Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Insurance Fraud Investigation Restricted Account to pay for a cost or expense incurred by the commissioner in the administration, investigation, and enforcement of this chapter, Section 34A-2-110, and Section 76-6-521.

Section 40. Section **31A-31-109** is amended to read:

31A-31-109. Civil penalties.

(1) In addition to other penalties provided by law, a person who violates this chapter:

(a) is subject to the following civil penalties:

(i) the person shall make full restitution; and

(ii) the person shall pay the costs of enforcement of this chapter for the case in which the person is found to have violated this chapter:

(A) as determined by the one or more authorized agencies involved; and

(B) including costs of:

(I) investigators;

(II) attorneys; and

(III) other public employees; and

(b) in the discretion of the court, may be required to pay to the state a civil penalty not to exceed three times that amount of value improperly sought or received from the fraudulent insurance act.

(2) (a) Money paid under Subsection (1)(a)(i) shall be paid to the person damaged by the fraudulent insurance act.

(b) Money paid under Subsection (1)(a)(ii) shall be paid to each applicable authorized agency in the following order:

(i) to the [~~General Fund as a dedicated credit of the department~~] Insurance Fraud Investigation Restricted Account created in Section 31A-31-108 for the costs of enforcement incurred by the [~~department~~] commissioner;

(ii) to the General Fund for the costs of enforcement incurred by a state agency other than the [~~department~~] commissioner;

(iii) to the applicable political subdivision for the costs of enforcement incurred by the political subdivision; and

(iv) to the applicable criminal investigative department or agency of the United States for the costs of enforcement incurred by the department or agency.

(c) Money paid under Subsection (1)(b) shall be paid into the General Fund.

(3) (a) A civil penalty assessed under Subsection (1) shall be awarded by the court as part of its judgment in both criminal and civil actions.

(b) A criminal action need not be brought against a person in order for that person to be civilly liable under this section.

Section 41. Section **31A-35-202** is amended to read:

31A-35-202. Board responsibilities.

(1) The board shall:

[~~(1)~~] (a) meet:

[~~(a)~~] (i) at least quarterly; and

[~~(b)~~] (ii) at the call of the chair;

[~~(2)~~] (b) make written recommendations to the commissioner for rules governing the following aspects of the bail bond surety insurance business:

[~~(a)~~] (i) qualifications, applications, and fees for obtaining:

[~~(i)~~] (A) a license required by this Section 31A-35-401; or

[~~(ii)~~] (B) a certificate;

[~~(b)~~] (ii) limits on the aggregate amounts of bail bonds;

[~~(c)~~] (iii) unprofessional conduct;

[~~(d)~~] (iv) procedures for hearing and resolving allegations of unprofessional conduct; and

[~~(e)~~] (v) sanctions for unprofessional conduct;

[~~(3)~~] (c) screen:

[~~(a)~~] (i) bail bond surety company license applications; and

[~~(b)~~] (ii) persons applying for a bail bond surety company license; and

[~~(4)~~] (d) recommend to the commissioner action regarding the granting, renewing, suspending, revoking, and reinstating of bail bond surety company license[~~; and~~].

(2) The board may:

[~~(5)~~] (a) conduct investigations of allegations of unprofessional conduct on the part of persons or bail bond sureties involved in the business of bail bond surety insurance; and

(b) provide the results of the investigations described in Subsection [~~(5)~~] (2)(a) to the commissioner with recommendations for:

(i) action; and

(ii) any appropriate sanctions.

Section 42. Section **31A-35-406** is amended to read:

31A-35-406. Renewal and reinstatement.

(1) (a) A license under this chapter expires annually on August 14. To renew its license under this chapter, on or before [~~the last day of the month in which the license expires~~] July 15 a bail bond surety company shall:

(i) complete and submit a renewal application to the department; and

(ii) pay the department the applicable renewal fee established in accordance with Section 31A-3-103.

(b) A bail bond surety company shall renew its license under this chapter annually as established by department rule, regardless of when the license is issued.

(2) A bail bond surety company may apply for reinstatement of an expired bail bond

surety company license within one year following the expiration of the license under Subsection (1) by:

(a) submitting the renewal application required by Subsection (1); and

(b) paying a license reinstatement fee established in accordance with Section 31A-3-103.

(3) If a bail bond surety company license has been expired for more than one year, the person applying for reinstatement of the bail bond surety license shall:

(a) submit a new application form to the commissioner; and

(b) pay the application fee established in accordance with Section 31A-3-103.

(4) If a bail bond surety company license is suspended, the applicant may not submit an application for a bail bond surety company license until after the end of the period of suspension.

(5) A fee collected under this section shall be deposited in the restricted account created in Section 31A-35-407.

Section 43. Section **31A-35-602** is amended to read:

31A-35-602. Place of business -- Records to be kept there.

(1) (a) [~~Every~~] A bail bond surety company shall have and maintain in this state a place of business:

(i) accessible to the public; and

(ii) where the bail bond surety company principally conducts transactions authorized by its bail bond surety company license.

(b) The address of the place of business described in Subsection (1)(a) shall appear upon:

(i) the application for a bail bond surety company license; and

(ii) [~~the~~] a bail bond surety company license issued under this chapter.

(c) In addition to complying with Subsection (1)(b), a bail bond surety company shall register and maintain with the commissioner the following at which the commissioner may contact the bail bond surety company:

(i) a telephone number; and

(ii) a business email address.

[~~(c)~~] (d) A bail bond surety company shall notify the commissioner [~~of any change in~~

~~the address required by this Subsection (1) within 20 days after the change.~~] within 20 days of a change in the bail bond surety company's:

(i) place of business address;

(ii) telephone number; or

(iii) business email address.

[~~(d)~~] (e) This section does not prohibit a bail bond surety company from maintaining the place of business required under this section in the licensee's residence, if the residence is in Utah.

(2) The bail bond surety company shall keep at the place of business described in Subsection (1)(a) the records required under Section 31A-35-604.

Section 44. Section **31A-37-103** is amended to read:

31A-37-103. Chapter exclusivity.

(1) Except as provided in [~~Subsection~~] Subsections (2) and (3) or otherwise provided in this chapter, a provision of this title other than this chapter does not apply to a captive insurance company.

(2) To the extent that a provision of the following does not contradict this chapter, the provision applies to a captive insurance company that receives a certificate of authority under this chapter:

(a) Chapter 2, Administration of the Insurance Laws;

(b) Chapter 4, Insurers in General;

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

(d) Chapter 14, Foreign Insurers;

(e) Chapter 16, Insurance Holding Companies;

(f) Chapter 17, Determination of Financial Condition;

(g) Chapter 18, Investments;

(h) Chapter 19a, Utah Rate Regulation Act;

(i) Chapter 27, Delinquency Administrative Action Provisions; and

(j) Chapter 27a, Insurer Receivership Act.

[~~(2)~~] (3) In addition to this chapter, and subject to Section 31A-37a-103:

(a) Chapter 37a, Special Purpose Financial Captive Insurance Company Act, applies to a special purpose financial captive insurance company; and

(b) for purposes of a special purpose financial captive insurance company, a reference in this chapter to "this chapter" includes a reference to Chapter 37a, Special Purpose Financial Captive Insurance Company Act.

Section 45. 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 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 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;

(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;

(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.

(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) 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) In addition to the information required by Subsections (4)(a), (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 must be renewed by July 1 of each year.

Section 46. Section **31A-37-504** is amended to read:

31A-37-504. Examinations for branch and alien captive insurance companies.

[~~(1) This section applies to all business written by a captive insurance company.~~]

[~~(2) Notwithstanding this section, the~~]

(1) The examination for a branch captive insurance company shall be of branch business and branch operations only, if the branch captive insurance company:

(a) provides annually to the commissioner a certificate of compliance, or an equivalent, issued by or filed with the licensing authority of the jurisdiction in which the branch captive insurance company is formed; and

(b) demonstrates to the commissioner's satisfaction that the branch captive insurance company is operating in sound financial condition in accordance with [~~all~~] the applicable laws and regulations of the jurisdiction in which the branch captive insurance company is formed.

[~~(3)~~] (2) As a condition of obtaining a certificate of authority, an alien captive insurance company shall grant authority to the commissioner to examine the affairs of the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed.

[~~(4) To the extent that the provisions of Chapters 2, 4, 5, 14, 16, 17, 18, 19a, 27, and 27a do not contradict this section, these chapters apply to captive insurance companies that have received a certificate of authority under this chapter.~~]

Section 47. Section **31A-40-308** is enacted to read:

31A-40-308. Material changes.

A professional employer organization shall notify the commissioner within 30 days of a change in:

(1) ownership;

(2) an address or telephone number; or

(3) a contact person.

Section 48. Section **59-9-105** is amended to read:

59-9-105. Tax on certain insurers to pay for relative value study and other publications or services.

(1) [~~Each~~] An insurer [~~providing~~] that provides coverage for motor vehicle liability, uninsured motorist, and personal injury protection shall pay to the State Tax Commission on or before March 31 of each year, a tax of .01% on the total premiums received for these coverages during the preceding calendar year from policies covering motor vehicle risks in this state.

(2) The taxable premium under this section shall be reduced by [~~all~~] the premiums returned or credited to policyholders on direct business subject to tax in this state.

(3) [~~All money~~] Money received by the state under this section shall be deposited [~~in the General Fund as a dedicated credit for the purpose of providing funds~~] into the Relative Value Study Restricted Account created in Subsection (4).

(4) (a) There is created in the General Fund a restricted account known as the "Relative Value Study Restricted Account."

(b) The Relative Value Study Restricted Account shall consist of the money received by the insurance commissioner under:

(i) Section 31A-2-208; and

(ii) this section.

(c) The insurance commissioner shall administer the Relative Value Study Restricted Account. Subject to appropriations by the Legislature, the insurance commissioner shall use the money deposited into the Relative Value Study Restricted Account to pay for [~~any~~] costs and expenses incurred by the [~~Insurance Department~~] insurance commissioner:

[~~(a)~~] (i) in conducting, maintaining, and administering the relative value study referred to in Section 31A-22-307;

[~~(b)~~] (ii) to prepare, publish, and distribute publications relating to insurance and consumers of insurance as provided in Section 31A-2-208; and

[~~(c)~~] (iii) in providing the services of the [~~Insurance Department~~] insurance commissioner through the use of:

[~~(i)~~] (A) electronic commerce; and

[~~(ii)~~] (B) other information technology.

Section 49. Section **63I-2-231** is amended to read:

63I-2-231. Repeal dates, Title 31A.

[~~(1) Section 31A-23a-415 is repealed July 1, 2011.~~]

[~~(2)~~] Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed January 1, 2013.

Section 50. Section **63J-1-602.2** is amended to read:

63J-1-602.2. List of nonlapsing funds and accounts -- Title 31 through Title 45.

(1) Appropriations from the Technology Development Restricted Account created in Section 31A-3-104.

(2) Appropriations from the Criminal Background Check Restricted Account created in

Section 31A-3-105.

(3) Appropriations from the Captive Insurance Restricted Account created in Section 31A-3-304, except to the extent that Section 31A-3-304 makes the money received under that section free revenue.

(4) Appropriations from the Title Licensee Enforcement Restricted Account created in Section 31A-23a-415.

(5) Appropriations from the Insurance Fraud Investigation Restricted Account created in Section 31A-31-108.

[~~(5)~~] (6) The fund for operating the state's Federal Health Care Tax Credit Program, as provided in Section 31A-38-104.

[~~(6)~~] (7) The Special Administrative Expense Account created in Section 35A-4-506.

[~~(7)~~] (8) Funding for a new program or agency that is designated as nonlapsing under Section 36-24-101.

[~~(8)~~] (9) The Oil and Gas Conservation Account created in Section 40-6-14.5.

[~~(9)~~] (10) The Off-Highway Access and Education Restricted Account created in Section 41-22-19.5.

Section 51. Section **63J-1-602.3** is amended to read:

63J-1-602.3. List of nonlapsing funds and accounts -- Title 46 through Title 60.

(1) Certain funds associated with the Law Enforcement Operations Account, as provided in Section 51-9-411.

(2) The Public Safety Honoring Heroes Restricted Account created in Section 53-1-118.

(3) Funding for the Search and Rescue Financial Assistance Program, as provided in Section 53-2-107.

(4) Appropriations made to the Department of Public Safety from the Department of Public Safety Restricted Account, as provided in Section 53-3-106.

(5) Appropriations to the Motorcycle Rider Education Program, as provided in Section 53-3-905.

(6) The DNA Specimen Restricted Account created in Section 53-10-407.

(7) Appropriations to the State Board of Education, as provided in Section 53A-17a-105.

(8) Certain funds appropriated from the Uniform School Fund to the State Board of Education for new teacher bonus and performance-based compensation plans, as provided in Section 53A-17a-148.

(9) Certain funds appropriated from the Uniform School Fund to the State Board of Education for implementation of proposals to improve mathematics achievement test scores, as provided in Section 53A-17a-152.

(10) The School Building Revolving Account created in Section 53A-21-401.

(11) Money received by the State Office of Rehabilitation for the sale of certain products or services, as provided in Section 53A-24-105.

(12) The State Board of Regents, as provided in Section 53B-6-104.

(13) Certain funds appropriated from the General Fund to the State Board of Regents for teacher preparation programs, as provided in Section 53B-6-104.

(14) A certain portion of money collected for administrative costs under the School Institutional Trust Lands Management Act, as provided under Section 53C-3-202.

(15) Certain surcharges on residence and business telecommunications access lines imposed by the Public Service Commission, as provided in Section 54-8b-10.

(16) Certain fines collected by the Division of Occupational and Professional Licensing for violation of unlawful or unprofessional conduct that are used for education and enforcement purposes, as provided in Section 58-17b-505.

(17) The Nurse Education and Enforcement Account created in Section 58-31b-103.

(18) The Certified Nurse Midwife Education and Enforcement Account created in Section 58-44a-103.

(19) Certain fines collected by the Division of Occupational and Professional Licensing for use in education and enforcement of the Security Personnel Licensing Act, as provided in Section 58-63-103.

(20) The Professional Geologist Education and Enforcement Account created in Section 58-76-103.

(21) Appropriations from the Relative Value Study Restricted Account created in Section 59-9-105.

[~~(21)~~] (22) Certain money in the Water Resources Conservation and Development Fund, as provided in Section 59-12-103.

Section 52. **Intent language regarding lapsing of money.**

It is the intent of the Legislature that money received by the Insurance Department during fiscal year 2010-11 under the following shall be considered dedicated credits and in closing out fiscal year 2010-11 the unspent dedicated credits shall lapse to the appropriate restricted account created by the amendments made by this bill:

(1) Section 31A-2-208;

(2) Section 31A-31-108;

(3) Section 31A-31-109; and

(4) Section 59-9-105.

Section 53. **Effective date.**

This bill takes effect on May 11, 2011, except that the amendments to Section 31A-3-304 in this bill take effect on July 1, 2013.

Section 54. **Retrospective operation.**

The amendments to the following sections in this bill have retrospective operation to January 1, 2011:

(1) Section 31A-22-701;

(2) Section 31A-30-103; and

(3) Section 31A-30-106.

Legislative Review Note
as of 11-18-10 10:22 AM

Office of Legislative Research and General Counsel

FISCAL NOTE

H.B. 19, 2011 General Session

SHORT TITLE: Insurance Law Related Amendments

SPONSOR: Dunnigan, J.

STATE OF UTAH

STATE GOVERNMENT (UCA 36-12-13(2)(b))

Enactment of this bill will shift funds from Dedicated Credits to two restricted accounts--Relative Value Study Restricted Account and Insurance Fraud Investigation Restricted Account. The projected amounts for FY 2011 for these dedicated credits are: $85,700 for Relative Value Study and $1,984,500 for Insurance Fraud Investigation. The FY 2010 ending balances for the dedicated credits were $208,688 for Relative Value Study and $73,923 for Insurance Fraud Investigation. There is no net change expected in the amount of funds collected for each account. Additionally, any possible collection of the $50,000 withdrawal fee included in Section 31A-4-115 would be excluded for captive insurance companies.

Raising the cap for nonlapsing funds in the Captive Insurance Restricted Account from $600,000 to $950,000 will result in a loss of revenue to the General Fund of up to $350,000 starting in FY 2014. The historical amount of lapsed funds to the General Fund includes: $8,598 (FY2007), $567,334 (FY2008), $445,328 (FY2009), and $637,220 (FY2010).

STATE BUDGET DETAIL TABLE	FY 2011	FY 2012	FY 2013
Revenue	$0	$0	$0
Expenditure:			
Dedicated Credits	($165,400)	($1,984,500)	$0
Dedicated Credits	($7,100)	($90,000)	$0
Restricted Funds	$165,400	$1,984,500	$0
Restricted Funds	$7,100	$90,000	$0
Total Expenditure	$0	$0	$0
Net Impact, All Funds (Rev.-Exp.)	$0	$0	$0
Net Impact, General/Education Funds	$0	$0	$0

LOCAL GOVERNMENTS (UCA 36-12-13(2)(c))

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for local governments.

DIRECT EXPENDITURES BY UTAH RESIDENTS AND BUSINESSES (UCA 36-12-13(2)(d))

Enactment of this bill likely will not result in direct, measurable expenditures by Utah residents or businesses.

1/22/2011, 02:50 PM, Lead Analyst: Lee, P.W./Attorney: PO

Office of the Legislative Fiscal Analyst