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H.B. 31
2nd Sub. (Gray)

Representative James A. Dunnigan proposes the following substitute bill:

INSURANCE AMENDMENTS

2022 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill amends the Insurance Code.

Highlighted Provisions:

This bill:

- amends definitions;
- defines terms;
- amends provisions related to the Insurance Department's participation in certain national organizations;
- modifies provisions regarding Title and Escrow Commission meetings;
- modifies provisions regarding an insurer's withdrawal from writing certain lines of insurance;
- amends required disclosures for a service contract and vehicle protection product warranty;
- enacts provisions related to mutual insurance holding companies;
- amends provisions related to the registration of insurers;
- requires a large insurance holding company to submit to the Insurance Department a Group Capital Calculation and Liquidity Stress Test results;
- amends provisions regarding the standards and management of an insurer within a

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holding company system;

- amends provisions related to the confidentiality of certain information obtained by the Utah Insurance Commissioner (commissioner);
- allows an unearned premium reserve fund to be released in accordance with the standards of the National Association of Insurance Commissioners;
- amends insurance form requirements;
- amends provisions regarding insurance policy renewal notification requirements;
- amends provisions related to an arbitration decision's resolution of a claim under an underinsured motorist policy;
- amends provisions related to accident and health insurance;
- clarifies provisions related to the discontinuance, nonrenewal, or modification of health benefit plans;
- clarifies provisions related to standardized health insurance identification cards;
- enacts provisions related to health insurance mandates;
- enacts provisions related to the renewal, cancellation, and modification of a group accident and health insurance plan;
- allows the commissioner to take action against a license of an insurance producer who fails to pay a final judgment rendered against the insurance producer by a court outside of this state;
- makes an affiliate of an insolvent insurer subject to Title 31A, Chapter 27a, Insurer Receivership Act;
- amends provisions related to a defense to a claim by a receiver;
- amends provisions related to a bail bond agency's required financial statements;
- amends provisions related to a drug manufacturer's required reports;
- modifies the Prescription Drug Price Transparency Act;
- amends the criminal offense of fraudulent insurance act; and
- makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

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

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

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

31A-2-210, as enacted by Laws of Utah 1985, Chapter 242

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

31A-4-115, as last amended by Laws of Utah 2017, Chapter 292

31A-5-506, as last amended by Laws of Utah 2007, Chapter 309

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

31A-16-105, as last amended by Laws of Utah 2017, Chapter 168

31A-16-106, as last amended by Laws of Utah 2015, Chapter 244

31A-16-109, as last amended by Laws of Utah 2019, Chapter 193

31A-17-408, as last amended by Laws of Utah 2001, Chapter 116

31A-17-601, as last amended by Laws of Utah 2020, Chapter 32

31A-21-201, as last amended by Laws of Utah 2021, Chapter 252

31A-21-303, as last amended by Laws of Utah 2020, Chapter 292

31A-22-305.3, as last amended by Laws of Utah 2020, Chapter 145

31A-22-602, as last amended by Laws of Utah 2021, Chapter 252

31A-22-618.6, as last amended by Laws of Utah 2021, Chapter 252

31A-22-618.7, as last amended by Laws of Utah 2021, Chapter 252

31A-22-618.8, as last amended by Laws of Utah 2021, Chapter 252

31A-22-627, as last amended by Laws of Utah 2021, Chapter 252

31A-22-636, as last amended by Laws of Utah 2011, Chapter 297

31A-23a-111, as last amended by Laws of Utah 2020, Chapter 32

31A-27a-104, as last amended by Laws of Utah 2013, Chapter 319

31A-27a-111, as last amended by Laws of Utah 2018, Chapter 319

31A-30-103, as last amended by Laws of Utah 2019, Chapter 193

31A-35-404, as last amended by Laws of Utah 2021, Chapter 252

31A-48-102, as enacted by Laws of Utah 2020, Chapter 198

31A-48-103, as last amended by Laws of Utah 2020, Sixth Special Session, Chapter 8
58-13-2.5, as enacted by Laws of Utah 2009, Chapter 14
63G-2-305, as last amended by Laws of Utah 2021, Chapters 148, 179, 231, 353, 373, and 382
76-6-521, as last amended by Laws of Utah 2019, Chapter 193
ENACTS:
31A-16-102.6, Utah Code Annotated 1953
31A-22-657, Utah Code Annotated 1953
31A-22-727, Utah Code Annotated 1953
REPEALS:
31A-17-519, as last amended by Laws of Utah 2019, Chapter 193

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

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

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

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

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

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

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

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

(b) (i) Beginning on the earlier of September 1, 2021, or the date on which the electronic verification system is functionally capable of facilitating a conditional medical cannabis card under this Subsection (1)(b), upon the entry of a recommending medical provider's medical cannabis recommendation for a patient in the state electronic verification system, either by the provider or the provider's employee or by a medical cannabis pharmacy

medical provider or medical cannabis pharmacy in accordance with Subsection 26-61a-501(11)(a), the department shall issue to the patient an electronic conditional medical cannabis card, in accordance with this Subsection (1)(b).

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

(A) 60 days; or

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

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

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

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

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

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

(ii) the individual is a Utah resident;

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

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

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

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

(A) is at least 18 years old;

(B) is a Utah resident;

(C) is the parent or legal guardian of a minor for whom the minor's qualified medical provider recommends a medical cannabis treatment, the individual petitions the Compassionate

Use Board under Section 26-61a-105, and the Compassionate Use Board recommends department approval of the petition;

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

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

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

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

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

(A) the minor has a qualifying condition;

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

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

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

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

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

the minor has adequate and safe access to the recommended medical cannabis treatment.

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

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

(ii) with the recommending medical provider; and

(iii) with information including:

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

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

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

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

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

(c) (i) If a recommending medical provider determines that, because of age, illness, or disability, a medical cannabis patient cardholder requires assistance in administering the medical cannabis treatment that the recommending medical provider recommends, the recommending medical provider may indicate the cardholder's need in the state electronic verification system, either directly or, for a limited medical provider, through the order described in Subsections 26-61a-106(1)(c) and (d).

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

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

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

treatment; and

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

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

(A) ingest or inhale medical cannabis;

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

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

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

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

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

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

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

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

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

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

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

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

(5) (a) Except as provided in Subsection (5)(b), a medical cannabis card that the

department issues under this section is valid for the lesser of:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

parent or legal guardian's associated medical cannabis guardian card.

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

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

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

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

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

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

(c) If a licensed medical cannabis pharmacy is not operating within the state after January 1, 2021, a cardholder under this section:

(i) may possess:

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

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

(C) marijuana drug paraphernalia; and

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

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

(a) violates this chapter; or

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

(i) a felony; or

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

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

(a) risks associated with medical cannabis treatment;

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

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

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

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

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

(i) to a nonresident patient; and

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

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

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

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

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

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

information for external research; and

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

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

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

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

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

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

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

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

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

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

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

(i) shall carry:

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

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

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

(A) unprocessed cannabis in medicinal dosage form; and

(B) a cannabis product in medicinal dosage form;

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

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

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

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

(i) guilty of an infraction; and

(ii) subject to a $100 fine.

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

(i) for a first offense:

(A) guilty of an infraction; and

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

(ii) for a second or subsequent offense:

(A) guilty of a class B misdemeanor; and

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

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

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

(i) for a first offense:

(A) guilty of an infraction; and

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

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

(f) A medical cannabis cardholder or a nonresident patient who possesses medical cannabis in an amount that is greater than twice the legal dosage limit is subject to the penalties

described in Title 58, Chapter 37, Utah Controlled Substances Act.

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

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

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

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

(i) for a first offense:

(A) guilty of an infraction; and

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

(ii) for a second or subsequent offense:

(A) guilty of a class B misdemeanor; and

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

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

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

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

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

whether the individual holds a valid medical cannabis card.

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

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

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

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

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

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

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

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

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

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

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

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

(6) "Agency" means:

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

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

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

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

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

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

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

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

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

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

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

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

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

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

(a) without individual underwriting or application; and

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

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

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

(a) that is open to the public;

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

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

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

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

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

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

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

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

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

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by a parent organization; and

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

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

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

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

(i) owned by the insureds; and

(ii) whose purpose is to insure risks of:

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

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

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

(b) a third party.

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

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

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

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

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

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

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

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

(A) for the life of the insured; or

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

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

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

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

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

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

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

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

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

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

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

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

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

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

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

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

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

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

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

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

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

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(40) "Credit property insurance" means insurance:

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

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

(41) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

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

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

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

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

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

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

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

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

(47) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

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

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

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

(b) "Eligible employee" includes:

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

[~~(A) works on a full-time basis;~~]

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

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

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

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

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

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

(i) an owner, sole proprietor, or partner who:

(A) works on a full-time basis;

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

(C) employs at least one common employee; and

(ii) an independent contractor if the individual is included under a health benefit plan of a small employer.

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

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

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

(iii) a dependent of an employer who does not meet the requirements of Subsection (53)(a)(i).

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

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

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

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

(ii) serious impairment to bodily functions; or

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

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

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

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

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

(a) an employee; or

(b) a dependent of an employee.

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

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

(A) one or more employers;

(B) one or more labor organizations; or

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

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

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

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

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

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

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

(i) a policyholder;

(ii) a certificate holder;

(iii) a subscriber; or

(iv) a covered individual:

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

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

(b) "Enrollee" includes an insured.

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

(a) the first day of coverage; or

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

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

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

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

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

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

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

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

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" does not include:

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

(A) an acknowledgment;

(B) a copy certification;

(C) jurat; and

(D) an oath or affirmation;

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

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

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

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

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

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

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

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

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

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

[~~(b) written:~~]

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

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

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

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

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

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

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

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

(B) rule.

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

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

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement;

(o) a binder; or

(p) an outline of coverage.

(69) "First party insurance" means an insurance policy or contract in which the insurer

agrees to pay a claim submitted to it by the insured for the insured's losses.

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

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

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

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

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

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

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

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

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

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

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

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

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

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

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

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

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

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

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

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

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

(A) the policy; or

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

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

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

[~~(78)~~] (79) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

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

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

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

thereof;

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

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

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics;

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

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

(A) limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

plan;

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

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

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

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

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

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

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

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

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

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

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

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

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

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

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

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

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

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

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

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

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

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

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

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

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

(b) "Insurance" includes:

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

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

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

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

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

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

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

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

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

(c) providing an annuity:

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

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

(d) providing the characteristic services of a motor club [~~as outlined in Subsection (125)~~];

(e) providing another person with insurance;

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) transacting or proposing a life settlement; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

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

(i) applies only to this title;

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

(iii) includes an enrollee.

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

(i) a fraternal benefit society;

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

(iii) a motor club;

(iv) an employee welfare plan;

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

(vi) a health maintenance organization.

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

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

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

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

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

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

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

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

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

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

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

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

(i) specific loan; or

(ii) credit transaction.

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

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

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

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

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

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

(b) through special enrollment.

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

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

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

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

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

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

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

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

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

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

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

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

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

(i) insurance on a human life; and

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

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

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

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

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

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

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

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

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

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

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

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

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

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

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

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

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

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

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

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

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

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

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

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

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

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

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

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

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

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

(b) (i) licensed under:

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

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

(C) Chapter 14, Foreign Insurers; and

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

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

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

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

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

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

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

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

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

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

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

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

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

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

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

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

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

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

(a) that is issued by an insurer; and

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

[~~(128)~~] (131) "Network provider" means a health care provider who has an agreement with a managed care organization to provide health care services to an enrollee with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly from the managed care organization.

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

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

(a) ships or hulls of ships;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) receives:

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

(ii) another government health benefit.

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

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

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

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

(a) an individual; or

(b) a family.

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

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

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

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

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

(i) purports to be an enforceable contract; and

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

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

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

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

(iii) a corporation licensed under:

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

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

(c) "Policy" does not include:

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

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

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

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

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

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

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

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

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

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

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

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

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

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

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

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

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

(i) from all hazards or causes; and

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

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

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

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

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

(a) is:

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

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

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

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

(i) the commissioner by rule; or

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

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

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

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

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

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

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

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

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

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

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

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

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

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

(b) "Rebate" does not include:

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

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

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

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

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

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

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

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

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

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

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

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

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

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

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

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

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

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

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

(a) an insurance policy; or

(b) an insurance certificate.

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

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

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

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

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

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

(b) "Security" does not include:

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

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

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

(a) common stock;

(b) preferred stock;

(c) debt obligations; and

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

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

(b) "Self-insurance" includes:

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

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

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

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

(ii) an arrangement with an independent contractor.

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

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

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

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

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

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) bail bond insurance; and

(c) fidelity insurance.

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

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

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

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

(c) "Excess surplus" means:

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

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

(I) 2.5; and

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

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

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(178)~~] (182) "Third party administrator" or "administrator" means a person who

collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

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

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

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

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

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

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

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

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

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

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

(B) Chapter 26, Insurance Adjusters; and

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

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

(i) that is:

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

(B) a bank or other financial institution that is subject to supervision or examination by

a federal or state banking authority; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[~~(184)~~] (188) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a

vehicle comprehensive or vehicle physical damage coverage [~~under~~] described in Subsection [~~(152)~~] (155).

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

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

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

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

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

Section 4. Section **31A-2-210** is amended to read:

31A-2-210. Participation in organizations.

(1) The commissioner and the Insurance Department shall maintain close relations with the commissioners of other states and shall participate in the activities and affairs of the [~~National Association of Insurance Commissioners~~] NAIC and other organizations to the extent, in the commissioner's judgment, these activities will promote the purposes of the Insurance Code. The actual and necessary expenses incurred by this participation shall be paid out of the Insurance Department appropriation. The commissioner may not make any commitments that are not terminable on reasonable notice by the commissioner.

(2) The commissioner shall participate in or provide support for participation in a professional organization that represents states or legislatures for the purpose of preserving state jurisdiction over the business of insurance.

Section 5. Section **31A-2-403** is amended to read:

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

(1) (a) Subject to Subsection (1)(b), there is created within the department the Title and

Escrow Commission that is comprised of five members who shall be, in accordance with Title 63G, Chapter 24, Part 2, Vacancies, appointed by the governor with the advice and consent of the Senate as follows:

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

(ii) two members shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) amended when a significant change occurs in any matter required to be disclosed

under this Subsection (2).

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

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

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

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

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

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

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

(a) Section 63A-3-106;

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

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

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

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

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

[~~(B) Notwithstanding Section 52-4-207, a commission member shall physically attend~~

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

(B) A commission member may, after providing advance notice to the commissioner, attend an in-person meeting through electronic means.

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

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

(c) The commissioner may call additional meetings:

(i) at the commissioner's discretion;

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

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

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

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

(7) The commissioner shall staff the commission.

Section 6. Section **31A-4-115** is amended to read:

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

(1) As used in this section, a "line of insurance" means:

(a) a general line of authority;

(b) a general line of insurance;

(c) a limited line insurance;

(d) the small employer group health benefit plan market when there is a discontinuance of all small employer health benefit plans under Subsection 31A-22-618.6(5)(e);

(e) the large employer group health benefit market when there is a discontinuance of all large employer health benefit plans under Subsection 31A-22-618.6(5)(e); or

(f) the individual health benefit plan market when there is a discontinuance of all

individual health benefit plans under Subsection 31A-22-618.7(3)(e).

[~~(1) (a)~~] (2) When an insurer intends to withdraw from writing a line of insurance in this state or to reduce its total annual premium volume by 75% or more, the insurer shall file with the commissioner a plan of orderly withdrawal.

[~~(b) For purposes of this section, a discontinuance of a health benefit plan is a withdrawal from a line of insurance under Subsections 31A-22-618.6(5) or 31A-22-618.7(3).~~]

[~~(2)~~] (3) An insurer's plan of orderly withdrawal shall:

(a) indicate the date the insurer intends to:

(i) begin the withdrawal plan; and

(ii) complete [~~its~~] the withdrawal plan; and

(b) include provisions for:

(i) meeting the insurer's contractual obligations;

(ii) providing services to [~~its~~] the insurer's Utah policyholders and claimants;

(iii) meeting applicable statutory obligations; and

(iv) the payment of a withdrawal fee of $50,000 to the department if the insurer's line of [~~business~~] insurance is not assumed or placed with another insurer approved by the commissioner.

[~~(3)~~] (4) The commissioner shall approve a plan of orderly withdrawal if the plan of orderly withdrawal adequately demonstrates that the insurer will:

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

(b) meet the insurer's contractual obligations;

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

(d) meet applicable statutory obligations.

[~~(4)~~] (5) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for orderly withdrawal.

[~~(5)~~] (6) The commissioner may require an insurer to increase the deposit maintained in accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in the name of the commissioner upon finding, after an adjudicative proceeding that:

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

(b) the insurer:

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

(ii) intends to:

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

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

[~~(6)~~] (7) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:

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

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

[~~(7)~~] (8) An insurer that withdraws from writing [~~all lines~~] a line of insurance in this state may not resume writing the line of insurance in this state for five years unless the commissioner finds that the prohibition should be waived because the waiver is:

(a) in the public interest to promote competition; or

(b) to resolve inequity in the marketplace.

[~~(8)~~] (9) The commissioner shall adopt rules necessary to implement this section.

(10) This section does not apply to an insurer that places coverage with an affiliate of the insurer with the same or similar coverage.

Section 7. Section **31A-5-506** is amended to read:

31A-5-506. Conversion of a domestic mutual into a stock corporation.

(1) (a) Except as provided in Subsection (1)(b), a domestic mutual may be converted into a domestic stock corporation under Subsections (2) through (11).

(b) A domestic mutual that is affiliated with other mutuals may not be converted into a stock corporation, unless all the affiliated mutuals are converted at the same time, or the commissioner finds that the interests of the policyholders of the remaining mutuals can be permanently protected by limitations on the corporate powers of the new stock corporation or on its authority to do business, or otherwise.

(2) The board shall pass a resolution stating that the conversion is in the best interests of the policyholders. The resolution shall specify the reasons for and the purposes of the proposed conversion, and how the conversion is expected to benefit policyholders.

(3) (a) Chapter 16, Insurance Holding Companies, applies to the conversion of a

domestic mutual into a stock corporation. In addition, the commissioner shall order the examination and appraisal of the corporation, unless the commissioner finds that:

(i) the resolution is defective upon its face; or

(ii) the basis or the purposes of the proposed conversion are contrary to law, to the interests of the policyholders, or to the public.

(b) The commissioner shall examine the company and all of its controlled affiliates under Section 31A-2-203 to determine their financial condition and whether they are operating in accordance with law.

(c) The commissioner shall appoint an appraisal committee, consisting of at least three qualified and disinterested persons with differing expertise, to determine the value of the corporation on the date of the resolution required by Subsection (2). Members of the appraisal committee shall receive reasonable compensation and shall be reimbursed for reasonable expenses in discharging their duties. They may employ consultants to advise them on technical problems of the appraisal, if necessary. The appraisal committee shall consider the assets and liabilities of the corporation, adjusting liabilities to take account of:

(i) the amounts of any reserves in excess of or below realistic estimates;

(ii) the value of the marketing organization;

(iii) the value of goodwill;

(iv) the going-concern value; and

(v) any other factor having an influence on the value of the corporation.

(4) When the examination and appraisal reports have been made to the commissioner, the commissioner shall make copies available to the board. The board shall then prepare and adopt by resolution a plan of conversion. The plan shall be consistent with Subsections (4)(a) through (e) and shall state how the requirements of those subsections are satisfied.

(a) The plan of conversion shall state the number of shares proposed to be authorized for the new stock corporation, their par value, if any, and the price per share at which they will be offered to policyholders. The price per share may not exceed 1/2 of the median equitable share of all policyholders under Subsection (4)(b).

(b) (i) When an insurer has the type of policies with no investment value to the policyholders, each person who has been a policyholder and has paid premiums within five years prior to the resolution under Subsection (2) is entitled, without additional payment, to as

much common stock of the new stock corporation as that person's equitable share of the value of the converting corporation will purchase. The equitable share is determined by the ratio which the net premium that person has paid to the corporation during the five years immediately preceding the resolution required by Subsection (2) bears to the total net premiums received by the corporation during the same period. The net premium is the gross premium less the return premium and dividends paid. If the equitable share would only purchase a fraction of a share of stock, the policyholder has the option of either receiving the value of the fractional share in cash or purchasing a full share by paying the balance in cash.

(ii) When an insurer has the type of policies with specifically attributable investment value to the policyholders, each policyholder is entitled, without additional payment, to as much common stock of the new stock corporation as the policyholder's investment value in the converting corporation will purchase, determined by the proportion of the policyholder's investment value to the aggregate investment values of all policyholders. If the policyholder's share would only purchase a fraction of a share of stock, the policyholder has the option of either receiving the value of the fractional share in cash or purchasing a full share by paying the balance in cash.

(c) A written offer shall be sent to each policyholder indicating the policyholder's individual equitable share and the terms upon which the policyholder may subscribe for stock.

(d) Common shares may not be subscribed by or issued to persons other than policyholders, until all subscriptions by the policyholders have been filled. After those subscriptions have been filled, any new issue of stock for five years after the conversion shall first be offered to the persons who have become shareholders under Subsection (4)(b) in proportion to their interests under Subsection (4)(b).

(e) A policyholder in a nonlife mutual may not receive a distribution of shares valued under Subsection (4)(b)(i), which distribution is greater than the amount the policyholder is entitled to under Section 31A-27a-701. Any excess over the policyholder's entitlement under Section 31A-27a-701 shall be distributed in accordance with Section 31A-27a-705.

(5) The plan of conversion shall be submitted to the commissioner for approval, together with:

(a) the proposed articles and bylaws of the new stock corporation which comply with Section 31A-5-203;

(b) any information specified under Subsection 31A-5-204(2), which the commissioner reasonably requires; and

(c) a projection of the planned or anticipated financial situation of the new corporation for five years after the conversion.

(6) The commissioner shall then hold a hearing. The notice of the hearing shall be mailed to each person who was a policyholder of the corporation on the date of the resolution required by Subsection (2). This notice shall include a copy of the plan of conversion and any comments the commissioner considers necessary to adequately inform the policyholders.

(7) The commissioner shall approve the plan of conversion unless the commissioner finds that the plan violates the law or is contrary to the interests of policyholders or the public.

(8) After approval under Subsection (7), the conversion plan shall be submitted to a vote of:

(a) for mutuals subject to Subsection (4)(b)(i), those persons who were policyholders of the mutual on the date of the resolution required by Subsection (2); or

(b) for mutuals subject to Subsection (4)(b)(ii), those persons who had investment values in their policies as of the date of the resolution required by Subsection (2).

(9) If the policyholders approve the conversion under Subsection (8), the commissioner shall issue a new certificate of authority. The issuance of the certificate is the conversion of the mutual to a stock corporation. This stock corporation is considered as being organized at the time the converted mutual was organized. Subject to the plan of conversion, the directors, officers, agents, and employees of the mutual shall continue in their same positions with the stock corporation.

(10) In the proposed conversion, the corporation may not pay any person compensation other than regular salaries to existing personnel and compensation for clerical and mailing expenses. With the commissioner's approval, the corporation may pay, at reasonable rates, for printing costs and for legal and other professional fees for services actually rendered. All expenses of the conversion, including the expenses incurred by the commissioner and the prorated salaries of any department staff members involved, shall be paid by the corporation being converted.

(11) The commissioner's approval of the plan of conversion satisfies the registration requirement of Section 31A-5-302.

(12) This section does not apply to a mutual reorganization or merger under Section 31A-16-102.6.

Section 8. Section **31A-6a-104** is amended to read:

31A-6a-104. Required disclosures.

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

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

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

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

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

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

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

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

(i) "Obligations of the warrantor under this vehicle protection product warranty are

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

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

(iii) as applicable:

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

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

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

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

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

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

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

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

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

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

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

(vii) state a term, restriction, or condition that governs cancellation of the service

contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder or service contract provider.

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

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

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

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

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

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

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

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

(i) a home warranty service contract; or

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

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

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

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

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

(A) immediately below the printed disclosure; and

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

(b) A vehicle protection product warranty shall contain a conspicuous statement in substantially the following form: "Purchase of this product is optional and is not required in

order to finance, lease, or purchase a motor vehicle."

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

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

Section 9. Section **31A-16-102.6** is enacted to read:

31A-16-102.6. Mutual insurance holding companies.

(1) As used in this section:

(a) "Intermediate holding company" means a holding company that:

(i) is a subsidiary of a mutual insurance holding company;

(ii) directly or through a subsidiary of the holding company, holds one or more subsidiary insurers, including a reorganized mutual insurer; and

(iii) if the subsidiary insurers were not held by the holding company, a majority of the voting shares of the subsidy insurers' capital stock would be required under this section to be owned by the mutual insurance holding company.

(b) "Majority of the voting shares" means the shares of a reorganized mutual insurer's capital stock that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the reorganized mutual insurer's capital stock for the election of directors and other matters submitted to a vote of the reorganized mutual insurer's shareholders.

(2) (a) With the commissioner's approval, a domestic mutual insurer may reorganize by forming a mutual insurance holding company in which:

(i) in accordance with the mutual insurance holding company's articles of incorporation and bylaws, the membership interests of the domestic mutual insurer's policyholders become membership interests in the mutual insurance holding company; and

(ii) the domestic mutual insurer is reorganized as a domestic stock insurance company.

(b) The commissioner may approve a domestic mutual insurer's reorganization if:

(i) the domestic mutual insurer's reorganization plan:

(A) properly protects the interests of the domestic mutual insurer's policyholders;

(B) is fair and equitable to the domestic mutual insurer's policyholders; and

(C) satisfies the requirements of Subsections 31A-16-103(8) through (10);

(ii) the initial shares of the reorganized domestic mutual insurer's capital stock are issued to the mutual insurance holding company or intermediate holding company; and

(iii) at all times, the mutual insurance holding company or intermediate holding company owns a majority of the voting shares of the reorganized domestic mutual insurer's capital stock.

(3) (a) With the commissioner's approval, a foreign mutual insurer that would qualify to become a domestic insurer organized under the laws of this state may reorganize by forming a mutual insurance holding company system in which:

(i) in accordance with the mutual insurance holding company's articles of incorporation and bylaws, the membership interests of the foreign mutual insurer's policyholders become membership interests in the mutual insurance holding company; and

(ii) the foreign mutual insurer is reorganized as a foreign stock insurance company.

(b) The commissioner may approve a foreign mutual insurer's reorganization if:

(i) the foreign mutual insurer's reorganization plan:

(A) complies with any other law or rule applicable to the foreign mutual insurer;

(B) properly protects the interests of the foreign mutual insurer's policyholders;

(C) is fair and equitable to the foreign mutual insurer's policyholders; and

(D) satisfies the requirements of Subsections 31A-16-103(8) through (10);

(ii) the initial shares of the reorganized foreign mutual insurer's capital stock are issued to the mutual insurance holding company or intermediate holding company; and

(iii) at all times, the mutual insurance holding company or intermediate holding company owns a majority of the voting shares of the reorganized foreign mutual insurer's capital stock.

(c) After a merger, the reorganized foreign mutual insurer may:

(i) remain a foreign corporation; and

(ii) with the commissioner's approval, be admitted to conduct business in this state.

(d) A foreign mutual insurer that is a party to a reorganization plan may redomesticate in this state by complying with the applicable requirements of this state and the foreign mutual insurer's state of domicile.

(4) (a) As a condition of approval, the commissioner may require a mutual insurer to

modify the mutual insurer's reorganization plan to protect the interests of the mutual insurer's policyholders.

(b) If the commissioner determines reasonably necessary, at the reorganizing mutual insurer's expense, the commissioner may retain a third-party consultant to assist the commissioner in reviewing the mutual insurer's reorganization plan.

(c) The commissioner has jurisdiction over a mutual insurance holding company or intermediate holding company organized in accordance with this section.

(d) Subject to the commissioner's approval, a reorganized mutual insurer or a stock insurance subsidiary within a mutual insurance company may issue a dividend or distribution to the mutual insurance holding company or intermediate holding company.

(5) (a) Subject to the provisions of this section, a mutual insurance holding company resulting from the reorganization of a domestic mutual insurer shall be incorporated in accordance with Chapter 5, Domestic Stock and Mutual Insurance Corporations.

(b) A mutual insurance holding company's articles of incorporation and bylaws are subject to commissioner's approval in the same manner as an insurance company's articles of incorporation and bylaws.

(6) (a) A mutual insurance holding company is:

(i) subject to Chapter 27a, Insurer Receivership Act; and

(ii) a party to any proceeding under Chapter 27a, Insurer Receivership Act, involving an insurer that is a subsidiary of the mutual insurance holding company as a result of a reorganization in accordance with this section.

(b) In a proceeding under Chapter 27a, Insurer Receivership Act, involving a reorganized mutual insurer, the assets of the mutual insurance holding company are assets of the estate of the reorganized mutual insurer for the purpose of satisfying the claims of the reorganized mutual insurer's policyholders.

(c) A mutual insurance holding company may be dissolved or liquidated only by:

(i) prior approval of the commissioner; or

(ii) court order in accordance with Chapter 27a, Insurer Receivership Act.

(7) (a) Section 31A-5-506 does not apply to a mutual insurer's reorganization or merger under this section.

(b) Section 31A-5-506 applies to demutualization of a mutual insurance holding

company.

(8) A membership interest in a domestic mutual insurance holding company is not a security under Utah law.

(9) (a) The ownership of a majority of the voting shares of a reorganized mutual insurer's capital stock includes indirect ownership through one or more intermediate holding companies in a corporate structure approved by the commissioner.

(b) The indirect ownership described in Subsection (9)(a) may not result in the mutual insurance holding company owning less than the equivalent of the majority of the voting shares of the reorganized mutual insurer's capital stock.

(10) (a) A mutual insurance holding company or intermediate holding company may not sell, transfer, assign, pledge, encumber, hypothecate, alienate, or subject to a security interest or lien the majority of the voting shares of the reorganized mutual insurer's capital stock.

(b) An act that violates Subsection (10)(a) is void in reverse chronological order of the date the act occurred.

(c) The majority of the voting shares of the reorganized mutual insurer's capital stock are not subject to execution and levy under Utah law.

(d) The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two or more reorganized mutual insurers, or two or more intermediate holding companies that were subsidiaries of the same mutual insurance holding company, are subject to the same requirements, restrictions, and limitations described in this section that applied to the shares of the merging or consolidating reorganized mutual insurers or intermediate holding companies before the merger or consolidation.

(11) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules to implement the provisions of this section.

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

31A-16-105. Registration of insurers.

(1) (a) An insurer that is authorized to do business in this state and that is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile, if the requirements and standards are substantially similar to those

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

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

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

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

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

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

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

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

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

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

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

(vi) reinsurance agreements;

(vii) dividends and other distributions to shareholders; and

(viii) consolidated tax allocation agreements;

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

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

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

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

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

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

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

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

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

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

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

following the declaration of the dividend or distribution.

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

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

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

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

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

(11) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer, or a disclaimer of affiliation may be filed by any insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation is considered to have been granted unless the commissioner, within 30 days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. If disallowed, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer is granted by the commissioner, or if the disclaimer is considered to have been approved.

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

(13) (a) The ultimate controlling person of an insurer subject to registration shall concurrently file with the registration an annual group capital calculation report as directed by the lead state commissioner.

(b) The annual group capital calculation report described in Subsection (13)(a) shall be filed with the lead state commissioner of the insurance holding company system as determined by the commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC.

(c) Subject to Subsections (13)(d) and (e), the following insurance holding company systems are exempt from filing the annual group capital calculation report described in Subsection (13)(a):

(i) an insurance holding company system that:

(A) has only one insurer within the insurance holding company's structure;

(B) writes business and is licensed only in the insurance holding company system's domestic state; and

(C) assumes no business from any other insurer;

(ii) an insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board unless:

(A) the lead state commissioner requests the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect; and

(B) the Federal Reserve Board cannot share the calculation with the lead state commissioner;

(iii) an insurance holding company system whose non-United States group-wide supervisor is located within a reciprocal jurisdiction as described in Subsection 31A-17-404(8) that recognizes the United States' state regulatory approach to group supervision and group capital; and

(iv) an insurance holding company system:

(A) that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined the information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook; and

(B) whose non-United States group-wide supervisor that is not located in a reciprocal jurisdiction recognizes and accepts, as specified by the lead state commissioner in regulation, the group capital calculation as the world-wide group capital assessment for United States insurance groups that operate in that jurisdiction.

(d) If, after consultation with other supervisors or officials, the lead state commissioner determines appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace, the lead state commissioner shall require the group capital calculation for United States operations of any non-United States based insurance holding company system.

(e) The lead state commissioner may:

(i) exempt the ultimate controlling person from filing the annual group capital calculation; or

(ii) accept a limited group capital filing or report in accordance with criteria as specified by the lead state commissioner in regulation.

(f) If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group capital calculation at the next annual filing date unless the lead state commissioner gives an extension based on reasonable grounds.

(14) (a) The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC liquidity stress test framework shall file the results of a specific year's liquidity stress test.

(b) The filing described in Subsection (14)(a) shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC.

(c) Any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured shall be effective on January 1 of the year following the calendar year in which the change is adopted.

(d) Insurers meeting at least one threshold of the NAIC liquidity stress test framework's scope criteria are scoped into the NAIC liquidity stress test framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial

Stability Task Force or the NAIC Financial Stability Task Force's successor, determines the insurer should not be scoped into the NAIC liquidity stress test framework for that data year.

(e) Insurers that do not meet at least one threshold of the NAIC liquidity stress test framework's scope criteria are scoped out of the NAIC liquidity stress test framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, determines the insurer should be scoped into the NAIC liquidity stress test framework for that data year.

(f) To avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis, the lead state insurance commissioner, in consultation with the Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, shall assess this concern as part of the lead state insurance commissioner's determination of whether an insurer is scoped into the NAIC liquidity stress test framework for a specified data year.

(g) The performance of, and filing of the results from, a specific year's liquidity stress test shall comply with:

(i) the NAIC liquidity stress test framework instructions and reporting templates for that year; and

(ii) lead state insurance commissioner determinations made in conjunction with the NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, provided within the NAIC liquidity stress test framework.

[~~(13)~~] (15) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for the filing is a violation of this section.

Section 11. Section **31A-16-106** is amended to read:

31A-16-106. Standards and management of an insurer within a holding company system.

(1) (a) Transactions within an insurance holding company system to which an insurer subject to registration is a party are subject to the following standards:

(i) the terms shall be fair and reasonable;

(ii) agreements for cost sharing services and management shall include the provisions required by rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah

Administrative Rulemaking Act;

(iii) charges or fees for services performed shall be reasonable;

(iv) expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(v) the books, accounts, and records of each party to all transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including the accounting information necessary to support the reasonableness of the charges or fees to the respective parties; [~~and~~]

(vi) the insurer's surplus held for policyholders, following any dividends or distributions to shareholder affiliates, shall be reasonable in relation to the insurer's outstanding liabilities and shall be adequate to its financial needs[~~.~~];

(vii) the commissioner may require the insurer to secure and maintain a deposit held by the commissioner or a bond, as determined by the insurer at the insurer's discretion, in an amount determined by the commissioner not to exceed the value of the agreement in any one year, if the commissioner:

(A) determines that the insurer is in a hazardous financial condition under Title 31A, Chapter 27a, Insurer Receivership Act, or a condition that would warrant a delinquency proceeding under Title 31A, Chapter 27a, Insurer Receivership Act; and

(B) believes that the insurers' affiliate may be unable to fulfill an agreement with the insurer if the insurer were put into liquidation;

(viii) all insurer records and data held by an affiliate:

(A) are the insurer's property;

(B) are subject to the insurer's control;

(C) are identifiable;

(D) are segregated or readily capable of segregation, at no additional cost to the insurer, from all other records and data;

(E) shall be provided to a receiver, at the insurer's request, including any information, software, licensing agreement, release, waiver, or any other thing required to access the records and data; and

(F) may be restricted in use by the affiliate if the affiliate is not operating the insurer's business; and

(ix) (A) all funds belonging to the insurer that an affiliate collects or holds are the exclusive property of the insurer and subject to the control of the insurer; and

(B) if the insurer is placed into receivership, any right of offset against the funds is subject to Title 31A, Chapter 27a, Insurance Receivership Act.

(b) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in Subsections (1)(a)(i) through (vi), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least 30 days before entering into the transaction, or within any shorter period the commissioner may permit, if the commissioner has not disapproved the transaction within the period. The notice for an amendment or modification shall include the reasons for the change and financial impact on the domestic insurer. Informal notice shall be reported, within 30 days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any:

(i) sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments if the transactions are equal to, or exceed as of the next preceding December 31:

(A) for nonlife insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus held for policyholders;

(B) for life insurers, 3% of the insurer's admitted assets;

(ii) loans or extensions of credit made to any person who is not an affiliate, if the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit if the transactions are equal to, or exceed as of the next preceding December 31:

(A) for nonlife insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus held for policyholders;

(B) for life insurers, 3% of the insurer's admitted assets;

(iii) reinsurance agreements or modifications to reinsurance agreements, including an agreement in which the reinsurance premium, a change in the insurer's liabilities, or the

projected reinsurance premium or a change in the insurer's liabilities in any of the current and succeeding three years, equals or exceeds 5% of the insurer's surplus held for policyholders, as of the next preceding December 31, including those agreements that may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and the non-affiliate that any portion of the assets will be transferred to one or more affiliates of the reinsurer;

(iv) all management agreements, service contracts, tax allocation agreements, and all cost-sharing arrangements;

(v) guarantees when made by a domestic insurer, except that:

(A) a guarantee that is quantifiable as to amount is not subject to the notice requirements of this Subsection (1) unless it exceeds the lesser of .5% of the insurer's admitted assets or 10% of surplus held for policyholders, as of the next preceding December 31; and

(B) a guarantee that is not quantifiable as to amount is subject to the notice requirements of this Subsection (1);

(vi) direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in the investments, exceeds 2.5% of the insurer's surplus to policyholders, except that a direct or indirect acquisition or investment in a subsidiary acquired pursuant to Section 31A-16-102.5, or in a non-subsidiary insurance affiliate that is subject to this chapter, is exempt from this Subsection (1)(b)(vi);

(vii) any material transactions, specified by rule, which the commissioner determines may adversely affect the interests of the insurer's policyholders; and

(viii) this Subsection (1) may not be interpreted to authorize or permit any transactions which would be otherwise contrary to law in the case of an insurer not a member of the same holding company system.

(c) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the holding company system if the purpose of the separate transactions is to avoid the statutory threshold amount and thus to avoid the review by the commissioner that would occur otherwise. If the commissioner determines that the separate transactions were entered into over any 12 month period for such a purpose, the commissioner may exercise the commissioner's authority under Section 31A-16-110.

(d) The commissioner, in reviewing transactions pursuant to Subsection (1)(b), shall consider whether the transactions comply with the standards set forth in Subsection (1)(a) and whether they may adversely affect the interests of policyholders.

(e) The commissioner shall be notified within 30 days of any investment of the domestic insurer in any one corporation, if the total investment in the corporation by the insurance holding company system exceeds 10% of the corporation's voting securities.

(2) (a) A domestic insurer may not pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(i) 30 days after the commissioner has received notice of the declaration of the dividend and has not within the 30-day period disapproved the payment; or

(ii) the commissioner has approved the payment within the 30-day period.

(b) For purposes of this Subsection (2), an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, fair market value of which, together with that of other dividends or distributions made within the preceding 12 months, exceeds the lesser of:

(i) 10% of the insurer's surplus held for policyholders as of the next preceding December 31;

(ii) the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending the next preceding December 31; or

(iii) an extraordinary dividend does not include pro rata distributions of any class of the insurer's own securities.

(c) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(d) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution, which is conditioned upon the commissioner's approval of the dividend or distribution, and the declaration shall confer no rights upon shareholders until:

(i) the commissioner has approved the payment of the dividend or distribution; or

(ii) the commissioner has not disapproved the payment within the 30-day period referred to in Subsection (2)(a).

(3) (a) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer may not be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this chapter.

(b) Nothing in this section precludes a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property, or services with one or more other persons under arrangements meeting the standards of Subsection (1)(a).

(c) (i) Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of a domestic insurer, shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity.

(ii) At least one person described in Subsection (3)(c)(i) shall be included in a quorum for the transaction of business at a meeting of the board of directors or a committee of the board of directors.

(d) Subsection (3)(c) does not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees of the board of directors that meet the requirements of Subsection (3)(c) with respect to the controlling entity.

(e) An insurer may make application to the commissioner for a waiver from the requirements of this Subsection (3) if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than $300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this Subsection (3) based upon unique circumstances. The commissioner may consider various factors, including:

(i) the type of business entity;

(ii) the volume of business written;

(iii) the availability of qualified board members; or

(iv) the ownership or organizational structure of the entity.

(4) (a) For purposes of this chapter, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

(i) the size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(ii) the extent to which the insurer's business is diversified among several lines of insurance;

(iii) the number and size of risks insured in each line of business;

(iv) the extent of the geographical dispersion of the insurer's insured risks;

(v) the nature and extent of the insurer's reinsurance program;

(vi) the quality, diversification, and liquidity of the insurer's investment portfolio;

(vii) the recent past and projected future trend in the size of the insurer's investment portfolio;

(viii) the surplus as regards policyholders maintained by other comparable insurers;

(ix) the adequacy of the insurer's reserves; and

(x) the quality and liquidity of investments in affiliates.

(b) The commissioner may treat an investment described in Subsection (4)(a)(x) as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.

Section 12. Section **31A-16-109** is amended to read:

31A-16-109. Confidentiality of information obtained by commissioner.

(1) (a) Documents, materials, or information obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made under Section 31A-16-107.5, and all information reported or provided to the department under Section 31A-16-105 or 31A-16-108.6, is proprietary, contains trade secrets, and is confidential.

(b) Any confidential document, material, or information described in Subsection (1)(a) is not subject to subpoena and may not be made public by the commissioner or any other person without the permission of the insurer, except the confidential document, material, or information may be provided to the insurance departments of other states, without the prior written consent of the insurer to which the confidential document, material, or information

pertains.

(c) The commissioner shall maintain the confidentiality of the following received in accordance with Section 31A-16-105 from an insurance holding company supervised by the Federal Reserve Board or any United States group-wide supervisor:

(i) a group capital calculation;

(ii) a group capital ratio produced within the group capital calculation; or

(iii) group capital information.

(d) The commissioner shall maintain the confidentiality of the liquidity stress test results, supporting disclosures, and any liquidity stress test information received in accordance with Section 31A-16-105 from an insurance holding company supervised by the Federal Reserve Board and non-United States group-wide supervisors.

(2) The commissioner and any person who receives documents, materials, or other information while acting under the authority of the commissioner or with whom the documents, materials, or other information are shared pursuant to this chapter shall keep confidential any confidential documents, materials, or information subject to Subsection (1).

(3) [~~(a)~~] To assist in the performance of the commissioner's duties, the commissioner:

[~~(i)~~] (a) may share documents, materials, proprietary and trade secret documents, or other information, including the confidential documents, materials, or information subject to Subsection (1), with the following if the recipient agrees in writing to maintain the confidentiality status of the document, material, or other information, and has verified in writing the legal authority to maintain confidentiality:

[~~(A)~~] (i) a state, federal, or international regulatory agency;

[~~(B)~~] (ii) the [~~National Association of Insurance Commissioners or an NAIC affiliate or subsidiary; or~~] NAIC;

(iii) a third-party consultant designated by the commissioner; or

[~~(C)~~] (iv) a state, federal, or international law enforcement authority, including a member of a supervisory college described in Section 31A-16-108.5;

[~~(ii)~~] (b) notwithstanding Subsection (1), may only share confidential documents, material, or information reported pursuant to Section 31A-16-105 or 31A-16-108.6 with a commissioner of a state having statutes or regulations substantially similar to Subsection (1) and who has agreed in writing not to disclose the documents, material, or information;

[~~(iii)~~] (c) may receive documents, materials, proprietary and trade secret information, or other information, including otherwise confidential documents, materials, or information from:

[~~(A)~~] (i) the [~~National Association of Insurance Commissioners~~] NAIC or an NAIC affiliate or subsidiary; or

[~~(B)~~] (ii) a regulatory or law enforcement official of a foreign or domestic jurisdiction;

[~~(iv)~~] (d) shall maintain as confidential any document, material, or information received under this section with notice or the understanding that it is confidential under the laws of the jurisdiction that is the source of the document, material, or information; and

[~~(v)~~] (e) shall enter into written agreements with the [~~National Association of Insurance Commissioners~~] NAIC or a third-party consultant designated by the commissioner governing sharing and use of information provided pursuant to this chapter consistent with this Subsection (3) that shall:

[~~(A)~~] (i) specify procedures and protocols regarding the confidentiality and security of information shared with the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries pursuant to this chapter, including procedures and protocols for sharing by the [~~National Association of Insurance Commissioners~~] NAIC with other state, federal, or international regulators;

[~~(B)~~] (ii) specify that ownership of information shared with the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries pursuant to this chapter remains with the commissioner and the [~~National Association of Insurance Commissioner's~~] NAIC's use of the information is subject to the direction of the commissioner;

[~~(C)~~] (iii) require prompt notice to be given to an insurer whose confidential information in the possession of the [~~National Association of Insurance Commissioners~~] NAIC pursuant to this chapter is subject to a request or subpoena to the [~~National Association of Insurance Commissioners~~] NAIC for disclosure or production; and

[~~(D)~~] (iv) require the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the [~~National Association of Insurance Commissioners~~] NAIC and

NAIC affiliates and subsidiaries pursuant to this chapter.

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

(5) A waiver of any applicable claim of confidentiality in the documents, materials, or information does not occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in Subsection (3).

(6) Documents, materials, or other information in the possession or control of the [~~National Association of Insurance Commissioners~~] NAIC pursuant to this chapter are:

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

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

(7) (a) The group capital calculation, including the resulting group capital ratio, and the liquidity stress test, including the liquidity stress test results and supporting disclosures, are:

(i) regulatory tools for assessing risk and capital adequacy; and

(ii) not a method to rank insurers or insurance holding company systems generally.

(b) Except as provided in Subsection (7)(c), an insurer, broker, or other person engaged in the business of insurance may not make, disseminate, or circulate to the public a materially false or misleading statement relating to an insurer's or insurer group's, or a component of an insurer's or insurer group's:

(i) group capital calculation;

(ii) group capital ratio;

(iii) liquidity stress test results; or

(iv) liquidity stress test supporting disclosures.

(c) If an insurer provides to the commissioner substantial proof that a statement described in Subsection (7)(b) is materially false or misleading, the insurer may publish an announcement in a written publication for the sole purpose of rebutting the materially false or misleading statement.

Section 13. Section **31A-17-408** is amended to read:

31A-17-408. Title insurance reserves.

(1) In addition to an adequate reserve for outstanding losses, a title insurance company

shall either:

(a) maintain and segregate an unearned premium reserve fund of not less than 10 cents for each $1,000 face amount of retained liability under each title insurance contract or policy on a single insurance risk issued; or

(b) have the commissioner review and approve a contract of reinsurance applicable to the title insurance company's policies, which contract adequately covers the exposure or risk which the unearned premium reserve would serve.

(2) The fund shall be maintained for the protection of policyholders and is not subject to the claims of stockholders or creditors other than policyholders.

(3) The title insurance company may release the fund in accordance with the standards of the NAIC Accounting Practices and Procedures Manual.

Section 14. Section **31A-17-601** is amended to read:

31A-17-601. Definitions.

As used in this part:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with Subsection 31A-17-602(5).

(2) "Corrective order" means an order issued by the commissioner specifying corrective action that the commissioner determines is required.

(3) "Health organization" means:

(a) an entity that is authorized under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) that is:

(i) a health maintenance organization;

(ii) a limited health service organization;

(iii) a dental or vision plan;

(iv) a hospital, medical, and dental indemnity or service corporation; or

(v) other managed care organization.

(4) "Life or accident and health insurer" means:

(a) an insurance company licensed to write life insurance, [~~disability~~] accident and health insurance, or both; or

(b) a licensed property casualty insurer writing only disability insurance.

(5) "Property and casualty insurer" means any insurance company licensed to write lines of insurance other than life but does not include a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer.

(6) "RBC" means risk-based capital.

(7) "RBC instructions" means the RBC report including the National Association of Insurance Commissioner's risk-based capital instructions that govern the year for which an RBC report is prepared.

(8) "RBC level" means an insurer's or health organization's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC.

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "Company action level RBC" means the product of 2.0 and its authorized control level RBC;

(c) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC; and

(d) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(9) (a) "RBC plan" means a comprehensive financial plan containing the elements specified in Subsection 31A-17-603(2).

(b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:

(i) the commissioner rejects the RBC plan; and

(ii) the plan is revised by the insurer or health organization, with or without the commissioner's recommendation.

(10) "RBC report" means the report required in Section 31A-17-602.

Section 15. Section **31A-21-201** is amended to read:

31A-21-201. Filing of forms.

(1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may not be used, sold, or offered for sale until the form is filed with the commissioner.

(b) A form is considered filed with the commissioner when the commissioner receives:

(i) the form;

(ii) the applicable filing fee as prescribed under Section 31A-3-103; and

(iii) the applicable transmittal forms as required by the commissioner.

(2) In filing a form for use in this state the insurer is responsible for assuring that the form is in compliance with this title and rules adopted by the commissioner.

(3) (a) The commissioner may prohibit the use of a form at any time upon a finding that:

(i) the form:

(A) is inequitable;

(B) is unfairly discriminatory;

(C) is misleading;

(D) is deceptive;

(E) is obscure;

(F) is unfair;

(G) encourages misrepresentation; or

(H) is not in the public interest;

(ii) the form provides benefits or contains another provision that endangers the solidity of the insurer;

(iii) except for a life or accident and health insurance policy form, the form is an insurance policy or application for an insurance policy, that fails to conspicuously provide:

(A) the exact name of the insurer; and

(B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy;

(iv) except an application required by Section 31A-22-635, the form is a life or accident and health insurance [~~policy~~] form that fails to conspicuously provide:

(A) the exact name of the insurer;

(B) the state of domicile of the insurer [~~filing the insurance policy or application for the insurance policy~~]; and

(C) for a life insurance policy only, the address of the administrative office of the insurer filing the form;

(v) the form violates a statute or a rule adopted by the commissioner; or

(vi) the form is otherwise contrary to law.

(b) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the day on which the commissioner issues the order, the use of the form be discontinued.

(ii) Once use of a form is prohibited, the form may not be used until appropriate changes are filed with and reviewed by the commissioner.

(iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to the existing policyholders.

(c) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:

(i) be in writing;

(ii) constitute an order; and

(iii) state the reasons for the prohibition.

(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that a form be subject to the commissioner's approval before an insurer uses the form.

(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for a form if the procedures are different from the procedures stated in this section.

(c) The type of form that under Subsection (4)(a) the commissioner may require approval of before use includes:

(i) a form for a particular class of insurance;

(ii) a form for a specific line of insurance;

(iii) a specific type of form; or

(iv) a form for a specific market segment.

(5) (a) An insurer shall maintain a complete and accurate record of the following for the time period described in Subsection (5)(b):

(i) a form:

(A) filed under this section for use; or

(B) that is in use; and

(ii) a document filed under this section with a form described in Subsection (5)(a)(i).

(b) The insurer shall maintain a record required under Subsection (5)(a) for the balance

of the current year, plus five years from:

(i) the last day on which the form is used; or

(ii) the last day an insurance policy that is issued using the form is in effect.

Section 16. Section **31A-21-303** is amended to read:

31A-21-303. Cancellation, issuance, renewal.

(1) (a) Except as otherwise provided in this section, other statutes, or by rule under Subsection (1)(c), this section applies to all policies of insurance:

(i) except for:

(A) life insurance;

(B) accident and health insurance; and

(C) annuities; and

(ii) if the policies of insurance are issued on forms that are subject to filing under Subsection 31A-21-201(1).

(b) A policy may provide terms more favorable to insureds than this section requires.

(c) The commissioner may by rule totally or partially exempt from this section classes of insurance policies in which the insureds do not need protection against arbitrary or unannounced termination.

(d) The rights provided by this section are in addition to and do not prejudice any other rights the insureds may have at common law or under other statutes.

(2) (a) As used in this Subsection (2), "grounds" means:

(i) material misrepresentation;

(ii) substantial change in the risk assumed, unless the insurer should reasonably have foreseen the change or contemplated the risk when entering into the contract;

(iii) substantial breaches of contractual duties, conditions, or warranties;

(iv) attainment of the age specified as the terminal age for coverage, in which case the insurer may cancel by notice under Subsection (2)(c), accompanied by a tender of proportional return of premium; or

(v) in the case of motor vehicle insurance, revocation or suspension of the driver's license of:

(A) the named insured; or

(B) any other person who customarily drives the motor vehicle.

(b) (i) Except as provided in Subsection (2)(e) or unless the conditions of Subsection (2)(b)(ii) are met, an insurance policy may not be canceled by the insurer before the earlier of:

(A) the expiration of the agreed term; or

(B) one year from the effective date of the policy or renewal.

(ii) Notwithstanding Subsection (2)(b)(i), an insurance policy may be canceled by the insurer for:

(A) nonpayment of a premium when due; or

(B) on grounds defined in Subsection (2)(a).

(c) (i) The cancellation provided by Subsection (2)(b), except cancellation for nonpayment of premium, is effective no sooner than 30 days after the delivery or first-class mailing of a written notice to the policyholder.

(ii) Cancellation for nonpayment of premium of a personal lines policy is effective no sooner than 10 days after delivery or first-class mailing of a written notice to the policyholder.

(iii) Cancellation for nonpayment of premium of a commercial lines policy is effective no sooner than 10 days after delivery or first-class mailing of a written notice to:

(A) the policyholder;

(B) each assignee of the policyholder, if the assignee is named in the policy; and

(C) each loss payee or mortgagee or lienholder under property insurance of the policyholder, if the loss payee, mortgagee, or lienholder is named in the policy.

(iv) An insurer shall deliver or send by first-class mail a copy of the notice of cancellation for nonpayment of premium described in Subsection (2)(c)(iii) to an agent of record of the policyholder on or before the day on which the insurer provides the notice to the policyholder.

(d) (i) Notice of cancellation for nonpayment of premium shall include a statement of the reason for cancellation.

(ii) Subsection (7) applies to the notice required for grounds of cancellation other than nonpayment of premium.

(e) (i) Subsections (2)(a) through (d) do not apply to any insurance contract that has not been previously renewed if the contract has been in effect less than 60 days on the day on which the written notice of cancellation is mailed or delivered.

(ii) A cancellation under this Subsection (2)(e) may not be effective until at least 10

days after the day on which a written notice of cancellation is delivered to the insured.

(iii) If the notice required by this Subsection (2)(e) is sent by first-class mail, postage prepaid, to the insured at the insured's last-known address, delivery is considered accomplished after the passing, since the mailing date, of the mailing time specified in the Utah Rules of Civil Procedure.

(iv) A policy cancellation subject to this Subsection (2)(e) is not subject to the procedures described in Subsection (7).

(3) A policy may be issued for a term longer than one year or for an indefinite term if the policy includes a clause providing for cancellation by the insurer by giving notice as provided in Subsection (4)(b)(i) 30 days before an anniversary date.

(4) (a) Subject to Subsections (2), (3), and (4)(b), a policyholder has a right to have the policy renewed:

(i) on the terms then being applied by the insurer to similar risks; and

(ii) (A) for an additional period of time equivalent to the expiring term if the agreed term is one year or less; or

(B) for one year if the agreed term is longer than one year.

(b) Except as provided in Subsections (4)(c) and (5), the right to renewal under Subsection (4)(a) is extinguished if:

(i) at least 30 days before the day on which the policy expires or completes an anniversary, the insurer delivers or sends by first-class mail a notice of intention not to renew the policy beyond the agreed expiration or anniversary date to the policyholder at the policyholder's last-known address;

(ii) not more than 45 nor less than 14 days before the day on which the renewal premium is due, the insurer delivers or sends by first-class mail a notice to the policyholder at the policyholder's last-known address, clearly stating:

(A) the renewal premium;

(B) how the renewal premium may be paid, including the due date for payment of the renewal premium;

(C) that failure to pay the renewal premium extinguishes the policyholder's right to renewal; and

(D) subject to Subsection (4)(e), that the extinguishment of the right to renew for

nonpayment of premium is effective no sooner than at least 10 days after delivery or first-class mailing of a written notice to the policyholder that the policyholder has failed to pay the premium when due;

(iii) the policyholder has:

(A) accepted replacement coverage; or

(B) requested or agreed to nonrenewal; or

(iv) the policy is expressly designated as nonrenewable.

(c) Unless the conditions of Subsection (4)(b)(iii) or (iv) apply, an insurer may not fail to renew an insurance policy as a result of a telephone call or other inquiry that:

(i) references a policy coverage; and

(ii) does not result in the insured requesting payment of a claim.

(d) Failure to renew under this Subsection (4) is subject to Subsection (5).

(e) (i) (A) If the policy is a personal lines policy, during the period that begins when an insurer delivers or sends by first-class mail the notice described in Subsection (4)(b)(ii)(D) and ends when the premium is paid, coverage exists and premiums are due.

(B) If the policy is a commercial lines policy, during the period that begins when an insurer delivers or sends by first-class mail the notice described in Subsection (2)(c)(iii) and ends when the premium is paid, coverage exists and premiums are due.

(ii) (A) If after receiving the notice required by Subsection (4)(b)(ii)(D) a personal lines policyholder fails to pay the renewal premium, the coverage is extinguished as of the date the renewal premium is originally due.

(B) If after receiving the notice required under Subsection (2)(c)(iii), a commercial lines policyholder fails to pay the renewal premium within the 10 days before the day on which cancellation for nonpayment is effective, the coverage is extinguished as of the day on which the renewal premium is originally due.

(iii) Delivery of the notice required by Subsection (2)(c)(iii), (2)(c)(iv), or (4)(b)(ii)(D) includes electronic delivery in accordance with Section 31A-21-316.

(iv) An insurer is not subject to Subsection (4)(b)(ii)(D) if:

(A) the insurer provides notice of the extinguishment of the right to renew for failure to pay premium at least 15 days, but no longer than 45 days, before the day on which the renewal payment is due; and

(B) the policy is a personal lines policy.

(v) Subsection (4)(b)(ii)(D) does not apply to a policy that provides coverage for 30 days or less.

(5) Notwithstanding Subsection (4), an insurer may not fail to renew the following personal lines insurance policies solely on the basis of:

(a) in the case of a motor vehicle insurance policy:

(i) a claim from the insured that:

(A) results from an accident in which:

(I) the insured is not at fault; and

(II) the driver of the motor vehicle that is covered by the motor vehicle insurance policy is 21 years of age or older; and

(B) is the only claim meeting the condition of Subsection (5)(a)(i)(A) within a 36-month period;

(ii) a single traffic violation by an insured that:

(A) is a violation of a speed limit under Title 41, Chapter 6a, Traffic Code;

(B) is not in excess of 10 miles per hour over the speed limit;

(C) is not a traffic violation under:

(I) Section 41-6a-601;

(II) Section 41-6a-604; or

(III) Section 41-6a-605;

(D) is not a violation by an insured driver who is younger than 21 years of age; and

(E) is the only violation meeting the conditions of Subsections (5)(a)(ii)(A) through (D) within a 36-month period; or

(iii) a claim for damage that:

(A) results solely from:

(I) wind;

(II) hail;

(III) lightning; or

(IV) an earthquake;

(B) is not preventable by the exercise of reasonable care; and

(C) is the only claim meeting the conditions of Subsections (5)(a)(iii)(A) and (B)

within a 36-month period; and

(b) in the case of a homeowner's insurance policy, a claim by the insured that is for damage that:

(i) results solely from:

(A) wind;

(B) hail; or

(C) lightning;

(ii) is not preventable by the exercise of reasonable care; and

(iii) is the only claim meeting the conditions of Subsections (5)(b)(i) and (ii) within a 36-month period.

(6) (a) (i) Subject to Subsection (6)(b), if the insurer offers or purports to renew the policy, but on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date if the insurer delivered or sent by first-class mail to the policyholder notice of the new terms or rates at least 30 days before the day on which the previous policy expires.

(ii) If the insurer did not give the prior notification described in Subsection (6)(a)(i) to the policyholder, the new terms or rates do not take effect until 30 days after the day on which the insurer delivers or sends by first-class mail the notice, in which case the policyholder may elect to cancel the renewal policy at any time during the 30-day period.

(iii) Return premiums or additional premium charges shall be calculated proportionately on the basis that the old rates apply.

(b) Except as provided in Subsection (6)(c), Subsection (6)(a) does not apply if the only change in terms that is adverse to the policyholder is:

(i) a rate increase generally applicable to the class of business to which the policy belongs;

(ii) a rate increase resulting from a classification change based on the altered nature or extent of the risk insured against; or

(iii) a policy form change made to make the form consistent with Utah law.

(c) Subsections (6)(b)(i) and (ii) do not apply to a rate increase of 25% or more on a commercial policy.

(7) (a) If a notice of cancellation or nonrenewal under Subsection (2)(c) does not state with reasonable precision the facts on which the insurer's decision is based, the insurer shall

send by first-class mail or deliver that information within 10 working days after receipt of a written request by the policyholder.

(b) A notice under Subsection (2)(c) is not effective unless it contains information about the policyholder's right to make the request.

(8) (a) An insurer that gives a notice of nonrenewal or cancellation of insurance on a motor vehicle insurance policy issued in accordance with the requirements of Chapter 22, Part 3, Motor Vehicle Insurance, for nonpayment of a premium shall provide notice of nonrenewal or cancellation to a lienholder if the insurer has been provided the name and mailing address of the lienholder.

(b) An insurer shall provide the notice described in Subsection (8)(a) to the lienholder by first-class mail or, if agreed by the parties, any electronic means of communication.

(c) A lienholder shall provide a current physical address of notification or an electronic address of notification to an insurer that is required to make a notification under Subsection (8)(a).

(9) If a risk-sharing plan under Section 31A-2-214 exists for the kind of coverage provided by the insurance being cancelled or nonrenewed, a notice of cancellation or nonrenewal required under Subsection (2)(c) or (4)(b)(i) may not be effective unless the notice contains instructions to the policyholder for applying for insurance through the available risk-sharing plan.

(10) There is no liability on the part of, and no cause of action against, any insurer, its authorized representatives, agents, employees, or any other person furnishing to the insurer information relating to the reasons for cancellation or nonrenewal or for any statement made or information given by them in complying or enabling the insurer to comply with this section unless actual malice is proved by clear and convincing evidence.

(11) This section does not alter any common law right of contract rescission for material misrepresentation.

(12) If a person is required to pay a premium in accordance with this section:

(a) the person may make the payment using:

(i) the United States Postal Service;

(ii) a delivery service the commissioner describes or designates by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; or

(iii) electronic means; and

(b) the payment is considered to be made:

(i) for a payment that is mailed using the method described in Subsection (12)(a)(i), on the date on which the payment is postmarked;

(ii) for a payment that is delivered using the method described in Subsection (12)(a)(ii), on the date on which the delivery service records or marks the payment as having been received by the delivery service; or

(iii) for a payment that is made using the method described in Subsection (12)(a)(iii), on the date on which the payment is made electronically.

Section 17. Section **31A-22-305.3** is amended to read:

31A-22-305.3. Underinsured motorist coverage.

(1) As used in this section:

(a) "Covered person" has the same meaning as defined in Section 31A-22-305.

(b) (i) "Underinsured motor vehicle" includes a motor vehicle, the operation, maintenance, or use of which is covered under a liability policy at the time of an injury-causing occurrence, but which has insufficient liability coverage to compensate fully the injured party for all special and general damages.

(ii) The term "underinsured motor vehicle" does not include:

(A) a motor vehicle that is covered under the liability coverage of the same policy that also contains the underinsured motorist coverage;

(B) an uninsured motor vehicle as defined in Subsection 31A-22-305(2);

(C) a motor vehicle owned or leased by:

(I) a named insured;

(II) a named insured's spouse; or

(III) a dependent of a named insured.

(2) (a) Underinsured motorist coverage under Subsection 31A-22-302(1)(c) provides coverage for a covered person who is legally entitled to recover damages from an owner or operator of an underinsured motor vehicle because of bodily injury, sickness, disease, or death.

(b) A covered person occupying or using a motor vehicle owned, leased, or furnished to the covered person, the covered person's spouse, or covered person's resident relative may recover underinsured benefits only if the motor vehicle is:

(i) described in the policy under which a claim is made; or

(ii) a newly acquired or replacement motor vehicle covered under the terms of the policy.

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

(i) any policy that is issued that does not include a renewal or reinstatement of an existing policy; or

(ii) a change to an existing policy that results in:

(A) a named insured being added to or deleted from the policy; or

(B) a change in the limits of the named insured's motor vehicle liability coverage.

(b) For new policies written on or after January 1, 2001, the limits of underinsured motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy, unless a named insured rejects or purchases coverage in a lesser amount by signing an acknowledgment form that:

(i) is filed with the department;

(ii) is provided by the insurer;

(iii) waives the higher coverage;

(iv) need only state in this or similar language that "underinsured motorist coverage provides benefits or protection to you and other covered persons for bodily injury resulting from an accident caused by the fault of another party where the other party has insufficient liability insurance"; and

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

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

(d) (i) Subsections (3)(b) and (c) apply retroactively to any claim arising on or after January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsections (3)(b) and (c) clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

(e) (i) As used in this Subsection (3)(e), "additional motor vehicle" means a change that increases the total number of vehicles insured by the policy, and does not include replacement, substitute, or temporary vehicles.

(ii) The adding of an additional motor vehicle to an existing personal lines or commercial lines policy does not constitute a new policy for purposes of Subsection (3)(a).

(iii) If an additional motor vehicle is added to a personal lines policy where underinsured motorist coverage has been rejected, or where underinsured motorist limits are lower than the named insured's motor vehicle liability limits, the insurer shall provide a notice to a named insured within 30 days that:

(A) in the same manner described in Subsection (3)(b)(iv), explains the purpose of underinsured motorist coverage; and

(B) encourages the named insured to contact the insurance company or insurance producer for quotes as to the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(f) A change in policy number resulting from any policy change not identified under Subsection (3)(a)(ii) does not constitute a new policy.

(g) (i) Subsection (3)(a) applies retroactively to any claim arising on or after January 1, 2001 for which, as of May 1, 2012, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsection (3)(a):

(A) does not enlarge, eliminate, or destroy vested rights; and

(B) clarifies legislative intent.

(h) A self-insured, including a governmental entity, may elect to provide underinsured motorist coverage in an amount that is less than its maximum self-insured retention under Subsections (3)(b) and (l) by issuing a declaratory memorandum or policy statement from the chief financial officer or chief risk officer that declares the:

(i) self-insured entity's coverage level; and

(ii) process for filing an underinsured motorist claim.

(i) Underinsured motorist coverage may not be sold with limits that are less than:

(i) $10,000 for one person in any one accident; and

(ii) at least $20,000 for two or more persons in any one accident.

(j) An acknowledgment under Subsection (3)(b) continues for that issuer of the underinsured motorist coverage until the named insured, in writing, requests different underinsured motorist coverage from the insurer.

(k) (i) The named insured's underinsured motorist coverage, as described in Subsection (2), is secondary to the liability coverage of an owner or operator of an underinsured motor vehicle, as described in Subsection (1).

(ii) Underinsured motorist coverage may not be set off against the liability coverage of the owner or operator of an underinsured motor vehicle, but shall be added to, combined with, or stacked upon the liability coverage of the owner or operator of the underinsured motor vehicle to determine the limit of coverage available to the injured person.

(l) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for policies existing on that date, the insurer shall disclose in the same medium as the premium renewal notice, an explanation of:

(A) the purpose of underinsured motorist coverage in the same manner as described in Subsection (3)(b)(iv); and

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

(ii) The disclosure required under this Subsection (3)(l) shall be sent to all named insureds that carry underinsured motorist coverage limits in an amount less than the named insured's motor vehicle liability policy limits or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(m) For purposes of this Subsection (3), a notice or disclosure sent to a named insured in a household constitutes notice or disclosure to all insureds within the household.

(4) (a) (i) Except as provided in this Subsection (4), a covered person injured in a motor vehicle described in a policy that includes underinsured motorist benefits may not elect

to collect underinsured motorist coverage benefits from another motor vehicle insurance policy.

(ii) The limit of liability for underinsured motorist coverage for two or more motor vehicles may not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident.

(iii) Subsection (4)(a)(ii) applies to all persons except a covered person described under Subsections (4)(b)(i) and (ii).

(b) (i) A covered person injured as a pedestrian by an underinsured motor vehicle may recover underinsured motorist benefits under any one other policy in which they are described as a covered person.

(ii) Except as provided in Subsection (4)(b)(iii), a covered person injured while occupying, using, or maintaining a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's spouse, or the covered person's resident parent or resident sibling, may also recover benefits under any one other policy under which the covered person is also a covered person.

(iii) (A) A covered person may recover benefits from no more than two additional policies, one additional policy from each parent's household if the covered person is:

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

(II) injured while occupying or using a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's resident parent, or the covered person's resident sibling.

(B) Each parent's policy under this Subsection (4)(b)(iii) is liable only for the percentage of the damages that the limit of liability of each parent's policy of underinsured motorist coverage bears to the total of both parents' underinsured coverage applicable to the accident.

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

(v) Underinsured coverage on a motor vehicle occupied at the time of an accident is primary coverage, and the coverage elected by a person described under Subsections 31A-22-305(1)(a), (b), and (c) is secondary coverage.

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

(vii) A covered person as described under Subsection (4)(b)(i) or is entitled to the

highest limits of underinsured motorist coverage under only one additional policy per household applicable to that covered person as a named insured, spouse, or relative.

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

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

(B) Except to the extent permitted by this Subsection (4), interpolicy stacking is prohibited for underinsured motorist coverage.

(c) Underinsured motorist coverage:

(i) does not cover any benefit paid or payable under Title 34A, Chapter 2, Workers' Compensation Act, except that the covered person is credited an amount described in Subsection 34A-2-106(5);

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

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

(iv) may be reduced by health insurance subrogation only after the covered person is made whole;

(v) may not be collected for bodily injury or death sustained by a person:

(A) while committing a violation of Section 41-1a-1314;

(B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated in violation of Section 41-1a-1314; or

(C) while committing a felony; and

(vi) notwithstanding Subsection (4)(c)(v), may be recovered:

(A) for a person [~~under 18 years of age~~] younger than 18 years old who is injured within the scope of Subsection (4)(c)(v), but is limited to medical and funeral expenses; or

(B) by a law enforcement officer as defined in Section 53-13-103, who is injured within the course and scope of the law enforcement officer's duties.

(5) The inception of the loss under Subsection 31A-21-313(1) for underinsured motorist claims occurs upon the date of the last liability policy payment.

(6) An underinsured motorist insurer does not have a right of reimbursement against a person liable for the damages resulting from an injury-causing occurrence if the person's liability insurer has tendered the policy limit and the limits have been accepted by the claimant.

(7) Except as otherwise provided in this section, a covered person may seek, subject to the terms and conditions of the policy, additional coverage under any policy:

(a) that provides coverage for damages resulting from motor vehicle accidents; and

(b) that is not required to conform to Section 31A-22-302.

(8) (a) When a claim is brought by a named insured or a person described in Subsection 31A-22-305(1) and is asserted against the covered person's underinsured motorist carrier, the claimant may elect to resolve the claim:

(i) by submitting the claim to binding arbitration; or

(ii) through litigation.

(b) Unless otherwise provided in the policy under which underinsured benefits are claimed, the election provided in Subsection (8)(a) is available to the claimant only, except that if the policy under which insured benefits are claimed provides that either an insured or the insurer may elect arbitration, the insured or the insurer may elect arbitration and that election to arbitrate shall stay the litigation of the claim under Subsection (8)(a)(ii).

(c) Once a claimant elects to commence litigation under Subsection (8)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the underinsured motorist coverage carrier.

(d) For purposes of the statute of limitations applicable to a claim described in Subsection (8)(a), if the claimant does not elect to resolve the claim through litigation, the claim is considered filed when the claimant submits the claim to binding arbitration in accordance with this Subsection (8).

(e) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (8)(a)(i) shall be resolved by a single arbitrator.

(ii) All parties shall agree on the single arbitrator selected under Subsection (8)(e)(i).

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

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

(i) each side shall select one arbitrator; and

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

(g) Unless otherwise agreed to in writing:

(i) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(e)(i); or

(ii) if an arbitration panel is selected under Subsection (8)(e)(iii):

(A) each party shall pay the fees and costs of the arbitrator selected by that party; and

(B) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(f)(ii).

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

(i) (i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f), 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of Subsections (9)(a) through (c) are satisfied.

(ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure shall be determined based on the claimant's specific monetary amount in the written demand for payment of uninsured motorist coverage benefits as required in Subsection (9)(a)(i)(A).

(iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to arbitration claims under this part.

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

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

(l) (i) Except as provided in Subsection (9), the amount of an arbitration award may not exceed the underinsured motorist policy limits of all applicable underinsured motorist policies, including applicable underinsured motorist umbrella policies.

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

(m) The arbitrator or arbitration panel may not decide an issue of coverage or extra-contractual damages, including:

(i) whether the claimant is a covered person;

(ii) whether the policy extends coverage to the loss; or

(iii) an allegation or claim asserting consequential damages or bad faith liability.

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

(o) If the arbitrator or arbitration panel finds that the arbitration is not brought, pursued, or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees and costs against the party that failed to bring, pursue, or defend the arbitration in good faith.

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

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

(ii) either party, within 20 days after service of the arbitration award:

(A) files a complaint requesting a trial de novo in the district court; and

(B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (8)(p)(ii)(A).

(q) (i) Upon filing a complaint for a trial de novo under Subsection (8)(p), a claim shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of Evidence in the district court.

(ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a complaint requesting a trial de novo under Subsection (8)(p)(ii)(A).

(r) (i) If the claimant, as the moving party in a trial de novo requested under Subsection (8)(p), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

(ii) If the underinsured motorist carrier, as the moving party in a trial de novo requested under Subsection (8)(p), does not obtain a verdict that is at least 20% less than the arbitration award, the underinsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (8)(r)(iv), the costs under this Subsection (8)(r) shall include:

(A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(B) the costs of expert witnesses and depositions.

(iv) An award of costs under this Subsection (8)(r) may not exceed $2,500 unless Subsection (9)(h)(iii) applies.

(s) For purposes of determining whether a party's verdict is greater or less than the

arbitration award under Subsection (8)(r), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(i) was not fully disclosed in writing prior to the arbitration proceeding; or

(ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(t) If a district court determines, upon a motion of the nonmoving party, that a moving party's use of the trial de novo process is filed in bad faith in accordance with Section 78B-5-825, the district court may award reasonable attorney fees to the nonmoving party.

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

(v) If there are multiple underinsured motorist policies, as set forth in Subsection (4), the claimant may elect to arbitrate in one hearing the claims against all the underinsured motorist carriers.

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

(i) a written demand for payment of underinsured motorist coverage benefits, setting forth:

(A) subject to Subsection (9)(l), the specific monetary amount of the demand, including a computation of the covered person's claimed past medical expenses, claimed past lost wages, and all other claimed past economic damages; and

(B) the factual and legal basis and any supporting documentation for the demand;

(ii) a written statement under oath disclosing:

(A) (I) the names and last known addresses of all health care providers who have rendered health care services to the covered person that are material to the claims for which the underinsured motorist benefits are sought for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) the names and last known addresses of the health care providers who have rendered health care services to the covered person, which the covered person claims are immaterial to the claims for which underinsured motorist benefits are sought, for a period of five years

preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised that have not been disclosed under Subsection (9)(a)(ii)(A)(I);

(B) (I) the names and last known addresses of all health insurers or other entities to whom the covered person has submitted claims for health care services or benefits material to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) the names and last known addresses of the health insurers or other entities to whom the covered person has submitted claims for health care services or benefits, which the covered person claims are immaterial to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation have not been disclosed;

(C) if lost wages, diminished earning capacity, or similar damages are claimed, all employers of the covered person for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised;

(D) other documents to reasonably support the claims being asserted; and

(E) all state and federal statutory lienholders including a statement as to whether the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens; and

(iii) signed authorizations to allow the underinsured motorist carrier to only obtain records and billings from the individuals or entities disclosed under Subsections (9)(a)(ii)(A)(I), (B)(I), and (C).

(b) (i) If the underinsured motorist carrier determines that the disclosure of undisclosed health care providers or health care insurers under Subsection (9)(a)(ii) is reasonably necessary, the underinsured motorist carrier may:

(A) make a request for the disclosure of the identity of the health care providers or health care insurers; and

(B) make a request for authorizations to allow the underinsured motorist carrier to only obtain records and billings from the individuals or entities not disclosed.

(ii) If the covered person does not provide the requested information within 10 days:

(A) the covered person shall disclose, in writing, the legal or factual basis for the failure to disclose the health care providers or health care insurers; and

(B) either the covered person or the underinsured motorist carrier may request the arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be provided if the covered person has elected arbitration.

(iii) The time periods imposed by Subsection (9)(c)(i) are tolled pending resolution of the dispute concerning the disclosure and production of records of the health care providers or health care insurers.

(c) (i) An underinsured motorist carrier that receives an election for arbitration or a notice of filing litigation and the demand for payment of underinsured motorist benefits under Subsection (9)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and receipt of the items specified in Subsections (9)(a)(i) through (iii), to:

(A) provide a written response to the written demand for payment provided for in Subsection (9)(a)(i);

(B) except as provided in Subsection (9)(c)(i)(C), tender the amount, if any, of the underinsured motorist carrier's determination of the amount owed to the covered person; and

(C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens, tender the amount, if any, of the underinsured motorist carrier's determination of the amount owed to the covered person less:

(I) if the amount of the state or federal statutory lien is established, the amount of the lien; or

(II) if the amount of the state or federal statutory lien is not established, two times the amount of the medical expenses subject to the state or federal statutory lien until such time as the amount of the state or federal statutory lien is established.

(ii) If the amount tendered by the underinsured motorist carrier under Subsection (9)(c)(i) is the total amount of the underinsured motorist policy limits, the tendered amount

shall be accepted by the covered person.

(d) A covered person who receives a written response from an underinsured motorist carrier as provided for in Subsection (9)(c)(i), may:

(i) elect to accept the amount tendered in Subsection (9)(c)(i) as payment in full of all underinsured motorist claims; or

(ii) elect to:

(A) accept the amount tendered in Subsection (9)(c)(i) as partial payment of all underinsured motorist claims; and

(B) continue to litigate or arbitrate the remaining claim in accordance with the election made under Subsections (8)(a), (b), and (c).

(e) If a covered person elects to accept the amount tendered under Subsection (9)(c)(i) as partial payment of all underinsured motorist claims, the final award obtained through arbitration, litigation, or later settlement shall be reduced by any payment made by the underinsured motorist carrier under Subsection (9)(c)(i).

(f) In an arbitration proceeding on the remaining underinsured claims:

(i) the parties may not disclose to the arbitrator or arbitration panel the amount paid under Subsection (9)(c)(i) until after the arbitration award has been rendered; and

(ii) the parties may not disclose the amount of the limits of underinsured motorist benefits provided by the policy.

(g) If the final award obtained through arbitration or litigation is greater than the average of the covered person's initial written demand for payment provided for in Subsection (9)(a)(i) and the underinsured motorist carrier's initial written response provided for in Subsection (9)(c)(i), the underinsured motorist carrier shall pay:

(i) the final award obtained through arbitration or litigation, except that if the award exceeds the policy limits of the subject underinsured motorist policy by more than $15,000, the amount shall be reduced to an amount equal to the policy limits plus $15,000; and

(ii) any of the following applicable costs:

(A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

(B) the arbitrator or arbitration panel's fee; and

(C) the reasonable costs of expert witnesses and depositions used in the presentation of evidence during arbitration or litigation.

(h) (i) The covered person shall provide an affidavit of costs within five days of an arbitration award.

(ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to which the underinsured motorist carrier objects.

(B) The objection shall be resolved by the arbitrator or arbitration panel.

(iii) The award of costs by the arbitrator or arbitration panel under Subsection (9)(g)(ii) may not exceed $5,000.

(i) (i) A covered person shall disclose all material information, other than rebuttal evidence, within 30 days after a covered person elects to submit a claim for underinsured motorist coverage benefits to binding arbitration or files litigation as specified in Subsection (9)(a).

(ii) If the information under Subsection (9)(i)(i) is not disclosed, the covered person may not recover costs or any amounts in excess of the policy under Subsection (9)(g).

(j) This Subsection (9) does not limit any other cause of action that arose or may arise against the underinsured motorist carrier from the same dispute.

(k) The provisions of this Subsection (9) only apply to motor vehicle accidents that occur on or after March 30, 2010.

(l) (i) The written demand requirement in Subsection (9)(a)(i)(A) does not affect the covered person's requirement to provide a computation of any other economic damages claimed, and the one or more respondents shall have a reasonable time after the receipt of the computation of any other economic damages claimed to conduct fact and expert discovery as to any additional damages claimed. The changes made by Laws of Utah 2014, Chapter 290, Section 11, and Chapter 300, Section 11, to this Subsection (9)(l) and Subsection (9)(a)(i)(A) apply to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

(ii) The changes made by Laws of Utah 2014, Chapter 290, Section 11, and Chapter 300, Section 11, under Subsections (9)(a)(ii)(A)(II) and (B)(II) apply to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

Section 18. Section **31A-22-602** is amended to read:

31A-22-602. Premium rates.

(1) Except as provided in Subsection 31A-22-701(4), this section does not apply to group accident and health insurance.

(2) The benefits in an accident and health insurance policy shall be reasonable in relation to the premiums charged.

(3) The commissioner shall prohibit the use of [~~a policy offering~~] an accident and health insurance form or rates if the form or rates do not satisfy Subsection (2).

Section 19. Section **31A-22-618.6** is amended to read:

31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit plans.

(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A group health benefit plan for a plan sponsor may be discontinued or nonrenewed:

(a) for noncompliance with the insurer's employer contribution requirements;

(b) if there is no longer any enrollee under the group health benefit plan who lives, resides, or works in:

(i) the service area of the insurer; or

(ii) the area for which the insurer is authorized to do business;

(c) 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~~] discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered individual; or

(d) for noncompliance with the insurer's minimum employee participation requirements, except as provided in Subsection (3).

(3) If a small employer no longer employs at least one eligible employee, a carrier may not discontinue or not renew the group health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows at the beginning of the plan year that the employer no longer has at least one eligible employee.

(4) (a) A small employer that, after purchasing a group 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 group health benefit plan purchased in the small group

market.

(b) A large employer that, after purchasing a group health benefit plan in the large group market, employs on average fewer than 51 eligible employees on each business day in a calendar year may continue to renew the group health benefit plan purchased in the large group market.

(5) A health benefit plan for a plan sponsor may be discontinued or nonrenewed 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 group health benefit plan delivered or issued for delivery in this state;

(ii) provides notice of the discontinuation in writing to each plan sponsor, employee, and dependent of an employee, at least 90 days before the day on which the coverage discontinues;

(iii) provides notice of the discontinuation in writing to the commissioner, and at least three working days before the day on which the notice is sent to each affected plan sponsor, employee, and dependent of an employee;

(iv) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other group health benefit plans currently being offered by the insurer in the market or, in the case of a large employer, any other group health benefit plans currently being offered in that market; and

(v) in exercising the option to discontinue [~~that~~] the group health benefit plan and in offering the option of coverage in this section, acts uniformly without regard to the claims experience of a plan sponsor, any health status-related factor relating to any covered participant or beneficiary, or any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the insurer:

(i) elects to discontinue offering all of the insurer's group health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets;

(ii) provides notice of the discontinuation in writing to each plan sponsor, employee, and dependent of an employee at least 180 days before the day on which the coverage discontinues;

(iii) provides notice of the discontinuation in writing to the commissioner in each state in which an affected insured individual is known to reside and, at least 30 working days before the day on which the notice is sent to each affected plan sponsor, employee, and dependent of an employee;

(iv) discontinues and nonrenews all plans issued or delivered for issuance in the market described in Subsection (5)(e)(i); and

(v) (A) provides a plan of orderly withdrawal as required by Section 31A-4-115[-]; or

(B) places the plan with an affiliate of the insurer with a plan of the same or similar coverage.

(6) (a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee whose coverage is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the day on which the employee's coverage discontinues; 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 discontinues under Subsection (6)(a), the insurer shall notify the eligible employee of the right to reenroll as described in Subsection (6)(b).

(d) An eligible employee's coverage may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the group 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.

(8) An insurer may modify a group health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans [~~with that product~~].

Section 20. Section **31A-22-618.7** is amended to read:

31A-22-618.7. Discontinuance, nonrenewal, and modification for individual health benefit plans.

(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all enrollees or dependents; and

(ii) at the option of the enrollee.

(b) Subsection (1)(a) applies regardless of:

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

(2) An individual health benefit plan may be discontinued or nonrenewed:

(a) if:

(i) there is no longer an enrollee under the individual health benefit 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) coverage is [~~terminated~~] discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered enrollee; or

(b) for coverage made available through an association, if:

(i) the enrollee's membership in the association ceases; and

(ii) the coverage is [~~terminated~~] discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered enrollee.

(3) An individual health benefit plan may be discontinued or nonrenewed if:

(a) a condition described in Subsection (2) exists;

(b) the enrollee fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the enrollee:

(i) performs an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular individual health benefit plan [~~product~~] delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing to each enrollee provided coverage at least 90 days before the day on which the coverage discontinues;

(B) provides notice of the discontinuation in writing to the commissioner and, at least three working days before the day on which the notice is sent, to each affected enrollee;

(C) offers to each covered enrollee on a guaranteed issue basis the option to purchase all other individual health benefit plans currently being offered by the insurer for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of covered enrollees or dependents of covered enrollees who may become eligible for coverage; or

(e) the insurer:

(i) elects to discontinue offering all of the insurer's individual health benefit plans in the individual market; [~~and~~]

(ii) [~~(A)~~] provides notice of the discontinuation in writing to each enrollee provided coverage at least 180 days before the day on which the coverage discontinues;

[~~(B)~~] (iii) provides notice of the discontinuation in writing to the commissioner in each state in which an affected enrollee is known to reside and, at least 30 working days before the day on which the insurer sends the notice, to each affected enrollee;

[~~(C)~~] (iv) discontinues and nonrenews all individual health benefit plans the insurer issues or delivers for issuance in the individual market; [~~and~~]

[~~(D)~~] (v) acts uniformly without regard to any health status-related factor of covered enrollees or dependents of covered enrollees who may become eligible for coverage[~~.~~]; and

(vi) (A) provides a plan of orderly withdrawal in accordance with Section 31A-4-115; or

(B) places the plan with an affiliate of the insurer with a plan of the same or similar coverage.

(4) An insurer may modify an individual health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all individual health benefit plans.

Section 21. Section **31A-22-618.8** is amended to read:

31A-22-618.8. Discontinuance and nonrenewal limitations for health benefit plans.

(1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health benefit plan under [~~Subsections~~] Subsection 31A-22-618.6(5)(e) [~~and~~] or 31A-22-618.7(3)(e) is prohibited from writing new business:

(a) in the market in this state for which the insurer discontinues or does not renew; and

(b) for a period of five years beginning on the day on which the last coverage that is discontinued.

(2) If an insurer is doing business in one established geographic service area of the state, [~~Sections~~] Subsections 31A-22-618.6(5)(e) and 31A-22-618.7(3)(e) apply only to the insurer's operations in that service area.

(3) The commissioner may, by rule or order, define the scope of service area.

Section 22. Section **31A-22-627** is amended to read:

31A-22-627. Coverage of emergency medical services.

(1) A health insurance policy or managed care organization contract:

(a) shall provide coverage of emergency services; and

(b) may not:

(i) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized;

(ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured; or

(iii) impose any cost-sharing requirement for out-of-network that exceeds the cost-sharing requirement imposed for in-network.

(2) (a) A health insurance policy or managed care organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's condition has been stabilized.

(b) If authorization described in Subsection (2)(a) is required, an insurer who does not accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected the request for authorization.

(3) For purposes of this section:

[~~(a) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention through a hospital emergency department to result in:~~]

[~~(i) placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;~~]

[~~(ii) serious impairment to bodily functions; or~~]

[~~(iii) serious dysfunction of any bodily organ or part.~~]

[~~(b)~~] (a) "Hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis.

[~~(c)~~] (b) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).

(4) Nothing in this section may be construed as:

(a) altering the level or type of benefits that are provided under the terms of a contract or policy; or

(b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract.

(5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has violated this section, the commissioner may:

(a) work with the insurer to improve the insurer's compliance with this section; or

(b) impose the following fines:

(i) not more than $5,000; or

(ii) twice the amount of any profit gained from violations of this section.

Section 23. Section **31A-22-636** is amended to read:

31A-22-636. Standardized health insurance information cards.

(1) As used in this section, "insurer" means:

(a) an insurer governed by this part as described in Section 31A-22-600;

(b) a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(c) a third party administrator; and

(d) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, medical, or conversion policy offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

(2) In accordance with Subsection (3), an insurer shall use and issue a health benefit plan information card for the insurer's enrollees upon the purchase or renewal of, or enrollment in, a health benefit plan [~~on or after July 1, 2010~~].

(3) The health benefit plan information card shall include:

(a) the covered person's name;

(b) the name of the carrier and the carrier network name;

(c) the contact information for the carrier or health benefit plan administrator;

(d) general information regarding copayments and deductibles; and

(e) an indication of whether the health benefit plan is regulated by the state.

(4) (a) The commissioner shall work with the Department of Health, the Health Data Authority, health care providers groups, and with state and national organizations that [~~are~~

~~developing~~] develop uniform standards for the electronic exchange of health insurance claims or uniform standards for the electronic exchange of clinical health records.

(b) [~~When the commissioner determines that the groups described in Subsection (4)(a) have reached a consensus regarding the electronic technology and standards necessary to electronically exchange insurance enrollment and coverage information, the commissioner shall begin the rulemaking process under~~] The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt standardized electronic interchange technology.

(c) After rules are adopted under Subsection (4)(a), health care providers and their licensing boards under Title 58, Occupations and Professions, and health facilities licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, shall work together to implement the adoption of card swipe technology.

Section 24. Section **31A-22-657** is enacted to read:

31A-22-657. Application of health insurance mandates.

(1) As used in this section:

(a) "Cost-sharing requirement" means a copayment, coinsurance, or deductible required by or on behalf of an enrollee in order to receive a benefit under a qualified high-deductible health plan.

(b) "Health savings account" means the same as that term is defined in 26 U.S.C. Sec. 223(d)(1).

(c) "Qualified high-deductible health plan" means a high-deductible health plan as defined in 26 U.S.C. Sec. 223(c)(2)(A) that is used in conjunction with a health savings account.

(d) "Cost-sharing mandate" means a statutory requirement limiting a cost-sharing requirement.

(2) (a) Except as provided in Subsection (2)(b), if under federal law, a cost-sharing mandate would result in an enrollee becoming ineligible for a health savings account, the cost-sharing mandate applies only to the enrollee's qualified high-deductible health plan after the enrollee satisfies the enrollee's health plan deductible.

(b) Subsection (2)(a) does not apply to an item or service that is preventive care under 26 U.S.C. Sec. 223(c)(2)(C).

Section 25. Section **31A-22-727** is enacted to read:

31A-22-727. Renewal, cancellation, and modification.

(1) Except as provided in Section 31A-22-618.6, for a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance, an insurer may:

(a) decline to renew the policy on the date the policy term expires for a reason stated in the policy; or

(b) cancel the policy at any time for:

(i) nonpayment of a premium when due;

(ii) intentional misrepresentation of a material fact in connection with the coverage;

(iii) performance of an act or practice that constitutes fraud in connection with the coverage; or

(iv) noncompliance with an employer eligibility provision.

(2) Except for a modification required by law, an insurer may only modify a policy at renewal.

(3) Subsection (2) does not apply to an endorsement by which the insurer:

(a) effectuates a request the policyholder made in writing; or

(b) exercises a specifically reserved right under the policy.

Section 26. Section **31A-23a-111** is amended to read:

31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (5);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-23a-113; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which the license is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) A line of authority issued under this chapter remains in force until:

(a) the qualifications pertaining to a line of authority are no longer met by the licensee; or

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5);

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(iii) lapses under Section 31A-23a-113; or

(iv) is voluntarily surrendered; or

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors.

(5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke:

(A) a license; or

(B) a line of authority;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a line of authority;

(iii) limit in whole or in part:

(A) a license; or

(B) a line of authority;

(iv) deny a license application;

(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

(vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and Subsection (5)(a)(v).

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee or license applicant:

(i) is unqualified for a license or line of authority under Section 31A-23a-104, 31A-23a-105, or 31A-23a-107;

(ii) violates:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person [~~in this state~~] within 60 days after the day on which the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the insurance producer's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) violates an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;

(xi) obtains or attempts to obtain a license through misrepresentation or fraud;

(xii) improperly withholds, misappropriates, or converts money or properties received in the course of doing insurance business;

(xiii) intentionally misrepresents the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) life settlement;

(xiv) has been convicted of:

(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;

(xv) admits or is found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere:

(A) uses fraudulent, coercive, or dishonest practices; or

(B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license or other professional or occupational license, or an equivalent to an insurance license or registration, or other professional or occupational license or registration:

(A) denied;

(B) suspended;

(C) revoked; or

(D) surrendered to resolve an administrative action;

(xviii) forges another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) improperly uses notes or another reference material to complete an examination for an insurance license;

(xx) knowingly accepts insurance business from an individual who is not licensed;

(xxi) fails to comply with an administrative or court order imposing a child support obligation;

(xxii) fails to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxiii) has been convicted of violating the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;

(xxiv) engages in a method or practice in the conduct of business that endangers the legitimate interests of customers and the public; or

(xxv) has been convicted of any criminal felony involving dishonesty or breach of trust and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

(6) A licensee under this chapter is subject to the penalties for acting as a licensee

without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(7) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in an order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval by the commissioner.

(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

(10) The commissioner shall by rule prescribe the license renewal and reinstatement

procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 27. Section **31A-27a-104** is amended to read:

31A-27a-104. Persons covered.

(1) This chapter applies to:

(a) an insurer who:

(i) is doing, or has done, an insurance business in this state; and

(ii) against whom a claim arising from that business may exist;

(b) a person subject to examination by the commissioner;

(c) an insurer who purports to do an insurance business in this state;

(d) an insurer who has an insured who is resident in this state; and

(e) in addition to Subsections (1)(a) through (d), a person doing business as follows:

(i) under Chapter 6a, Service Contracts;

(ii) under Chapter 7, Nonprofit Health Service Insurance Corporations;

(iii) under Chapter 8a, Health Discount Program Consumer Protection Act;

(iv) under Chapter 9, Insurance Fraternals;

(v) under Chapter 11, Motor Clubs;

(vi) under Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups;

(vii) as a bail bond surety company under Chapter 35, Bail Bond Act;

(viii) under Chapter 37, Captive Insurance Companies Act;

(ix) a title insurance company;

(x) a prepaid health care delivery plan; and

(xi) a person not described in Subsections (1)(e)(i) through (x) that is organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state.

(2) Notwithstanding Sections 31A-1-301 and 31A-27a-102, this chapter does not apply to a person licensed by the insurance commissioner as one or more of the following in this state unless the person engages in the business of insurance as an insurer, is an affiliate as defined in Subsection 31A-1-301(5), or is a person under the control of an affiliate:

(a) an insurance agency;

(b) an insurance producer;

(c) a limited line producer;

(d) an insurance consultant;

(e) a managing general agent;

(f) reinsurance intermediary;

(g) an individual title insurance producer or agency title insurance producer;

(h) a third party administrator;

(i) an insurance adjustor;

(j) a life settlement provider; or

(k) a life settlement producer.

Section 28. Section **31A-27a-111** is amended to read:

31A-27a-111. Actions by and against the receiver.

(1) (a) An allegation by the receiver of improper or fraudulent conduct against a person may not be the basis of a defense to the enforcement of a contractual obligation owed to the insurer by a third party.

(b) Notwithstanding Subsection (1)(a), a third party described in this Subsection (1) is not barred by this section from seeking to establish independently as a defense that the conduct is materially and substantially related to the contractual obligation for which enforcement is sought.

(2) (a) Subject to Subsection (2)(b), a prior wrongful or negligent action of any present or former receiver, receiver's assistant, receiver's contractor, officer, manager, director, trustee, owner, employee, or agent of the insurer may not be asserted as a defense to a claim by the receiver:

(i) under a theory of:

(A) estoppel;

(B) comparative fault;

(C) intervening cause;

(D) proximate cause;

(E) reliance; or

(F) mitigation of damages; or

(ii) otherwise.

(b) Notwithstanding Subsection (2)(a):

(i) the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract; and

(ii) a principal under a surety bond or a surety undertaking is entitled to credit against any reimbursement obligation to the receiver for the value of any property pledged to secure the reimbursement obligation to the extent that:

(A) the receiver has possession or control of the property; or

(B) the insurer or its agents misappropriated, including commingling, the property.

(c) Evidence of fraud in the inducement is admissible only if it is contained in the records of the insurer.

(3) Action or inaction by an insurance regulatory authority may not be asserted as a defense to a claim by the receiver.

(4) (a) Subject to Subsection (4)(b), a judgment or order entered against an insured or the insurer in contravention of a stay or injunction under this chapter, or at any time by default or collusion, may not be considered as evidence of liability or of the quantum of damages in adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.

(b) Subsection (4)(a) does not apply to an affected guaranty association's claim for amounts paid on a settlement or judgment in pursuit of the affected guaranty association's statutory obligations.

(5) (a) Subject to Subsection (5)(b), the following do not affect the amount that a receiver may recover from a third party, regardless of any provision in an agreement to the contrary:

(i) the insurer's insolvency; or

(ii) the insurer's or receiver's failure to pay all or a portion of an amount or a claim to the third party.

(b) If an agreement between the insurer and a third party requires a payment by the insurer before the insurer may recover from the third party, the amount the receiver may recover from the third party under Subsection (5)(a) is limited to an amount equal to the greater of:

(i) the amount paid by the insurer or by another person on behalf of the insurer to the third party; or

(ii) the amount allowed as a claim for payment under:

(A) an approved report described in Section 31A-27a-608;

(B) an order of the receivership court; or

(C) a plan of rehabilitation.

(6) The receiver may not be considered a governmental entity for the purposes of any state law awarding fees to a litigant who prevails against a governmental entity.

Section 29. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with this chapter, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) (a) "Bona fide employer association" means an association of employers:

(i) that meets the requirements of [~~Subsection 31A-22-701(2)(b)~~] Section 31A-22-505;

(ii) in which the employers of the association, either directly or indirectly, exercise control over the plan;

(iii) that is organized:

(A) based on a commonality of interest between the employers and their employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits; and

(B) to act in the best interests of its employers to provide benefits for the employer's employees and their spouses and dependents, and other benefits relating to employment; and

(iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

(b) The commissioner shall consider the following with regard to determining whether an association of employers is a bona fide employer association under Subsection (4)(a):

(i) how association members are solicited;

(ii) who participates in the association;

(iii) the process by which the association was formed;

(iv) the purposes for which the association was formed, and what, if any, were the pre-existing relationships of its members;

(v) the powers, rights and privileges of employer members; and

(vi) who actually controls and directs the activities and operations of the benefit programs.

(5) "Carrier" means a person that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) another person providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the commissioner in accordance with Section 31A-30-105.

(8) "Covered carrier" means an individual carrier or small employer carrier subject to this chapter.

(9) "Covered individual" means an individual who is covered under a health benefit plan subject to this chapter.

(10) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(11) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(12) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(13) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(14) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(15) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(16) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(17) "Premium" means money paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including fees or other contributions associated with the health benefit plan.

(18) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(19) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

Section 30. Section **31A-35-404** is amended to read:

31A-35-404. Minimum financial requirements for bail bond agency license.

(1) (a) A bail bond agency that pledges the assets of a letter of credit from a Utah depository institution in connection with a judicial proceeding shall maintain an irrevocable letter of credit with a minimum face value of $300,000 assigned to the state from a Utah depository institution.

(b) Notwithstanding Subsection (1)(a), a bail bond agency described in Subsection (1)(a) that is licensed under this chapter on or before December 31, 1999, shall maintain an irrevocable letter of credit with a minimum face value of $250,000 assigned to the state from a Utah depository institution.

(2) (a) A bail bond agency that pledges personal or real property, or both, as security for a bail bond in connection with a judicial proceeding shall maintain a verified financial statement for the [~~current~~] bail bond agency's immediately preceding fiscal year:

(i) reviewed by a certified public accountant; and

(ii) showing a minimum net worth of:

(A) $300,000, at least $100,000 of which is in liquid assets; or

(B) if the bail bond agency is licensed under this chapter on or before December 31, 1999, $250,000, at least $50,000 of which is in liquid assets.

(b) For purposes of this Subsection (2), only real or personal property located in Utah may be included in the net worth of the bail bond agency.

(3) A bail bond agency shall maintain a qualifying power of attorney issued by a surety

insurer if:

(a) the bail bond agency is the agent of the surety insurer; and

(b) the surety insurer:

(i) sells bail bonds;

(ii) is in good standing in its state of domicile; and

(iii) is granted a certificate to write bail bonds in Utah.

(4) The commissioner may revoke the license of a bail bond agency that fails to maintain the minimum financial requirements required under this section.

(5) The commissioner may set by rule the limits on the aggregate amounts of bail bonds issued by a bail bond agency.

Section 31. Section **31A-48-102** is amended to read:

31A-48-102. Definitions.

As used in this chapter:

(1) (a) "Drug" means [~~a prescription drug, as defined in Section 58-17b-102.~~] a substance that is:

(i) (A) intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans; and

(B) recognized in or in a supplement to the official United States Pharmacopoeia, the Homeopathic Pharmacopoeia of the United States, or the official National Formulary;

(ii) required by an applicable federal or state law or rule to be dispensed by prescription only;

(iii) restricted to administration by practitioners only;

(iv) a substance other than food intended to affect the structure or a function of the human body; or

(v) intended for use as a component of a substance described in Subsection (1)(a)(i), (ii), (iii), or (iv).

(b) "Drug" does not include a dietary supplement.

(2) "Insurer" means the same as that term is defined in Section 31A-22-634.

(3) "Manufacturer" means a person that is engaged in the manufacturing of a drug that is available for purchase by residents of the state.

(4) "Rebate" means the same as that term is defined in Section 31A-46-102.

(5) "Wholesale acquisition cost" means the same as that term is defined in 42 U.S.C. Sec. 1395w-3a.

Section 32. Section **31A-48-103** is amended to read:

31A-48-103. Manufacturer reports -- Insurer report -- Publication by department.

(1) (a) A manufacturer of a drug shall, beginning January 1, 2022, report to the department the information described in Subsection (1)(b) no more than 30 days after the day on which an increase to the wholesale acquisition cost of the drug results in an increase to the wholesale acquisition cost of the drug of:

(i) greater than 16% over the preceding two calendar years; or

(ii) greater than 10% over the preceding calendar year.

(b) The manufacturer shall report:

(i) (A) the name of the drug;

(B) the dosage form of the drug; and

(C) the strength of the drug;

(ii) whether the drug is a brand name drug or a generic drug;

(iii) the effective date of the increase in the wholesale acquisition cost of the drug;

(iv) a written description, suitable for public release, of the factors that led to the increase in the wholesale acquisition cost of the drug and the significance of each factor;

(v) the manufacturer's aggregate company-wide research and development costs for the most recent year for which final audit data is available;

(vi) the name of each of the manufacturer's drugs approved by the United States Food and Drug Administration during the preceding three calendar years; and

(vii) the names of drugs manufactured by the manufacturer that lost patent exclusivity in the United States during the preceding three calendar years.

(c) Subsection (1)(a) applies only to a drug with a wholesale acquisition cost of at least $100 for a 30-day supply before the effective date of the increase in the wholesale acquisition cost of the drug.

(d) [~~A manufacturer's obligations under this Subsection (1) are fully satisfied by submission~~] The quality and types of information and data that a manufacturer submits under this Subsection (1) shall be consistent with the quality and types of information and data that

the manufacturer includes in the manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K or any other public disclosure.

(e) The department shall consult with representatives of manufacturers to establish a single, standardized format for reporting information under this section that minimizes the administrative burden of reporting for manufacturers and the state.

[~~(f) Information provided to the department under Subsection (1)(b) may not be released in a manner that:~~]

[~~(i) would allow for the identification of an individual drug, therapeutic class of drugs, or manufacturer; or~~]

[~~(ii) is likely to compromise the financial, competitive, or proprietary nature of the information.~~]

(2) On or before August 1, 2021, and on or before August 1 of each year thereafter, an insurer shall report to the department in aggregate the following information for the preceding calendar year for health benefit plans offered by the insurer:

(a) for the 25 drugs for which spending by the insurer was the greatest, after adjusting for rebates:

(i) the name of the drug;

(ii) the dosage form of the drug; and

(iii) the strength of the drug;

(b) the percentage increase over the previous year in net spending for all drugs, after adjusting for rebates; [~~and~~]

(c) the percentage of the increase in premiums over the previous year attributable to all drugs; and

(d) the percentage of the increase in premiums over the previous year attributable to specialty drugs.

(3) The department shall publish on the department's website:

(a) no later than 60 days after receiving the information, information reported to the department under Subsection (1); and

(b) no later than December 1 of each year, information reported to the department under Subsection (2).

(4) (a) The department may not publish information under [~~Subsection (3)(b)~~] this

section in a manner that:

(i) allows the identity of an insurer to be determined[.];

(ii) allows for the identification of an individual drug, a therapeutic class of drugs, or a manufacturer; or

(iii) is likely to compromise the financial, competitive, or proprietary nature of the information.

(b) The commissioner shall classify each record submitted under this section as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

(5) The department shall make rules, as necessary, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to promote comparability of information reported to the department under this chapter.

Section 33. Section **58-13-2.5** is amended to read:

58-13-2.5. Standard of proof for emergency care when immunity does not apply.

(1) A person who is a health care provider as defined in Section 78B-3-403 who provides emergency care in good faith, but is not immune from suit because of an expectation of payment, a legal duty to respond, or other reason under Section 58-13-2, may only be liable for civil damages if fault, as defined in Section 78B-5-817, is established by clear and convincing evidence.

(2) For purposes of Subsection (1), "emergency care" means the treatment of an emergency medical condition, as defined in Section [~~31A-22-627~~] 31A-1-301, from the time that the person presents at the emergency department of a hospital and including any subsequent transfer to another hospital, until the condition has been stabilized and the patient is either discharged from the emergency department or admitted to another department of the hospital.

(3) This section does not apply to emergency care provided by a physician if:

(a) the physician has a previously established physician/patient relationship with the patient outside of the emergency room;

(b) the patient has been seen in the last three months by the physician for the same condition for which emergency care is sought; and

(c) the physician can access and consult the patient's relevant medical care records

while the physician is making decisions about and providing the emergency care.

(4) (a) Nothing in this section may be construed as:

(i) altering the applicable standard of care for determining fault; or

(ii) applying the standard of proof of clear and convincing evidence to care outside of emergency care and the mandatory legal duty to treat.

(b) This section applies to emergency care given after June 1, 2009.

(5) This section sunsets in accordance with Section 63I-1-258.

Section 34. Section **63G-2-305** is amended to read:

63G-2-305. Protected records.

The following records are protected if properly classified by a governmental entity:

(1) trade secrets as defined in Section 13-24-2 if the person submitting the trade secret has provided the governmental entity with the information specified in Section 63G-2-309;

(2) commercial information or nonindividual financial information obtained from a person if:

(a) disclosure of the information could reasonably be expected to result in unfair competitive injury to the person submitting the information or would impair the ability of the governmental entity to obtain necessary information in the future;

(b) the person submitting the information has a greater interest in prohibiting access than the public in obtaining access; and

(c) the person submitting the information has provided the governmental entity with the information specified in Section 63G-2-309;

(3) commercial or financial information acquired or prepared by a governmental entity to the extent that disclosure would lead to financial speculations in currencies, securities, or commodities that will interfere with a planned transaction by the governmental entity or cause substantial financial injury to the governmental entity or state economy;

(4) records, the disclosure of which could cause commercial injury to, or confer a competitive advantage upon a potential or actual competitor of, a commercial project entity as defined in Subsection 11-13-103(4);

(5) test questions and answers to be used in future license, certification, registration, employment, or academic examinations;

(6) records, the disclosure of which would impair governmental procurement

proceedings or give an unfair advantage to any person proposing to enter into a contract or agreement with a governmental entity, except, subject to Subsections (1) and (2), that this Subsection (6) does not restrict the right of a person to have access to, after the contract or grant has been awarded and signed by all parties:

(a) a bid, proposal, application, or other information submitted to or by a governmental entity in response to:

(i) an invitation for bids;

(ii) a request for proposals;

(iii) a request for quotes;

(iv) a grant; or

(v) other similar document; or

(b) an unsolicited proposal, as defined in Section 63G-6a-712;

(7) information submitted to or by a governmental entity in response to a request for information, except, subject to Subsections (1) and (2), that this Subsection (7) does not restrict the right of a person to have access to the information, after:

(a) a contract directly relating to the subject of the request for information has been awarded and signed by all parties; or

(b) (i) a final determination is made not to enter into a contract that relates to the subject of the request for information; and

(ii) at least two years have passed after the day on which the request for information is issued;

(8) records that would identify real property or the appraisal or estimated value of real or personal property, including intellectual property, under consideration for public acquisition before any rights to the property are acquired unless:

(a) public interest in obtaining access to the information is greater than or equal to the governmental entity's need to acquire the property on the best terms possible;

(b) the information has already been disclosed to persons not employed by or under a duty of confidentiality to the entity;

(c) in the case of records that would identify property, potential sellers of the described property have already learned of the governmental entity's plans to acquire the property;

(d) in the case of records that would identify the appraisal or estimated value of

property, the potential sellers have already learned of the governmental entity's estimated value of the property; or

(e) the property under consideration for public acquisition is a single family residence and the governmental entity seeking to acquire the property has initiated negotiations to acquire the property as required under Section 78B-6-505;

(9) records prepared in contemplation of sale, exchange, lease, rental, or other compensated transaction of real or personal property including intellectual property, which, if disclosed prior to completion of the transaction, would reveal the appraisal or estimated value of the subject property, unless:

(a) the public interest in access is greater than or equal to the interests in restricting access, including the governmental entity's interest in maximizing the financial benefit of the transaction; or

(b) when prepared by or on behalf of a governmental entity, appraisals or estimates of the value of the subject property have already been disclosed to persons not employed by or under a duty of confidentiality to the entity;

(10) records created or maintained for civil, criminal, or administrative enforcement purposes or audit purposes, or for discipline, licensing, certification, or registration purposes, if release of the records:

(a) reasonably could be expected to interfere with investigations undertaken for enforcement, discipline, licensing, certification, or registration purposes;

(b) reasonably could be expected to interfere with audits, disciplinary, or enforcement proceedings;

(c) would create a danger of depriving a person of a right to a fair trial or impartial hearing;

(d) reasonably could be expected to disclose the identity of a source who is not generally known outside of government and, in the case of a record compiled in the course of an investigation, disclose information furnished by a source not generally known outside of government if disclosure would compromise the source; or

(e) reasonably could be expected to disclose investigative or audit techniques, procedures, policies, or orders not generally known outside of government if disclosure would interfere with enforcement or audit efforts;

(11) records the disclosure of which would jeopardize the life or safety of an individual;

(12) records the disclosure of which would jeopardize the security of governmental property, governmental programs, or governmental recordkeeping systems from damage, theft, or other appropriation or use contrary to law or public policy;

(13) records that, if disclosed, would jeopardize the security or safety of a correctional facility, or records relating to incarceration, treatment, probation, or parole, that would interfere with the control and supervision of an offender's incarceration, treatment, probation, or parole;

(14) records that, if disclosed, would reveal recommendations made to the Board of Pardons and Parole by an employee of or contractor for the Department of Corrections, the Board of Pardons and Parole, or the Department of Human Services that are based on the employee's or contractor's supervision, diagnosis, or treatment of any person within the board's jurisdiction;

(15) records and audit workpapers that identify audit, collection, and operational procedures and methods used by the State Tax Commission, if disclosure would interfere with audits or collections;

(16) records of a governmental audit agency relating to an ongoing or planned audit until the final audit is released;

(17) records that are subject to the attorney client privilege;

(18) records prepared for or by an attorney, consultant, surety, indemnitor, insurer, employee, or agent of a governmental entity for, or in anticipation of, litigation or a judicial, quasi-judicial, or administrative proceeding;

(19) (a) (i) personal files of a state legislator, including personal correspondence to or from a member of the Legislature; and

(ii) notwithstanding Subsection (19)(a)(i), correspondence that gives notice of legislative action or policy may not be classified as protected under this section; and

(b) (i) an internal communication that is part of the deliberative process in connection with the preparation of legislation between:

(A) members of a legislative body;

(B) a member of a legislative body and a member of the legislative body's staff; or

(C) members of a legislative body's staff; and

(ii) notwithstanding Subsection (19)(b)(i), a communication that gives notice of legislative action or policy may not be classified as protected under this section;

(20) (a) records in the custody or control of the Office of Legislative Research and General Counsel, that, if disclosed, would reveal a particular legislator's contemplated legislation or contemplated course of action before the legislator has elected to support the legislation or course of action, or made the legislation or course of action public; and

(b) notwithstanding Subsection (20)(a), the form to request legislation submitted to the Office of Legislative Research and General Counsel is a public document unless a legislator asks that the records requesting the legislation be maintained as protected records until such time as the legislator elects to make the legislation or course of action public;

(21) research requests from legislators to the Office of Legislative Research and General Counsel or the Office of the Legislative Fiscal Analyst and research findings prepared in response to these requests;

(22) drafts, unless otherwise classified as public;

(23) records concerning a governmental entity's strategy about:

(a) collective bargaining; or

(b) imminent or pending litigation;

(24) records of investigations of loss occurrences and analyses of loss occurrences that may be covered by the Risk Management Fund, the Employers' Reinsurance Fund, the Uninsured Employers' Fund, or similar divisions in other governmental entities;

(25) records, other than personnel evaluations, that contain a personal recommendation concerning an individual if disclosure would constitute a clearly unwarranted invasion of personal privacy, or disclosure is not in the public interest;

(26) records that reveal the location of historic, prehistoric, paleontological, or biological resources that if known would jeopardize the security of those resources or of valuable historic, scientific, educational, or cultural information;

(27) records of independent state agencies if the disclosure of the records would conflict with the fiduciary obligations of the agency;

(28) records of an institution within the state system of higher education defined in Section 53B-1-102 regarding tenure evaluations, appointments, applications for admissions, retention decisions, and promotions, which could be properly discussed in a meeting closed in

accordance with Title 52, Chapter 4, Open and Public Meetings Act, provided that records of the final decisions about tenure, appointments, retention, promotions, or those students admitted, may not be classified as protected under this section;

(29) records of the governor's office, including budget recommendations, legislative proposals, and policy statements, that if disclosed would reveal the governor's contemplated policies or contemplated courses of action before the governor has implemented or rejected those policies or courses of action or made them public;

(30) records of the Office of the Legislative Fiscal Analyst relating to budget analysis, revenue estimates, and fiscal notes of proposed legislation before issuance of the final recommendations in these areas;

(31) records provided by the United States or by a government entity outside the state that are given to the governmental entity with a requirement that they be managed as protected records if the providing entity certifies that the record would not be subject to public disclosure if retained by it;

(32) transcripts, minutes, recordings, or reports of the closed portion of a meeting of a public body except as provided in Section 52-4-206;

(33) records that would reveal the contents of settlement negotiations but not including final settlements or empirical data to the extent that they are not otherwise exempt from disclosure;

(34) memoranda prepared by staff and used in the decision-making process by an administrative law judge, a member of the Board of Pardons and Parole, or a member of any other body charged by law with performing a quasi-judicial function;

(35) records that would reveal negotiations regarding assistance or incentives offered by or requested from a governmental entity for the purpose of encouraging a person to expand or locate a business in Utah, but only if disclosure would result in actual economic harm to the person or place the governmental entity at a competitive disadvantage, but this section may not be used to restrict access to a record evidencing a final contract;

(36) materials to which access must be limited for purposes of securing or maintaining the governmental entity's proprietary protection of intellectual property rights including patents, copyrights, and trade secrets;

(37) the name of a donor or a prospective donor to a governmental entity, including an

institution within the state system of higher education defined in Section 53B-1-102, and other information concerning the donation that could reasonably be expected to reveal the identity of the donor, provided that:

(a) the donor requests anonymity in writing;

(b) any terms, conditions, restrictions, or privileges relating to the donation may not be classified protected by the governmental entity under this Subsection (37); and

(c) except for an institution within the state system of higher education defined in Section 53B-1-102, the governmental unit to which the donation is made is primarily engaged in educational, charitable, or artistic endeavors, and has no regulatory or legislative authority over the donor, a member of the donor's immediate family, or any entity owned or controlled by the donor or the donor's immediate family;

(38) accident reports, except as provided in Sections 41-6a-404, 41-12a-202, and 73-18-13;

(39) a notification of workers' compensation insurance coverage described in Section 34A-2-205;

(40) (a) the following records of an institution within the state system of higher education defined in Section 53B-1-102, which have been developed, discovered, disclosed to, or received by or on behalf of faculty, staff, employees, or students of the institution:

(i) unpublished lecture notes;

(ii) unpublished notes, data, and information:

(A) relating to research; and

(B) of:

(I) the institution within the state system of higher education defined in Section 53B-1-102; or

(II) a sponsor of sponsored research;

(iii) unpublished manuscripts;

(iv) creative works in process;

(v) scholarly correspondence; and

(vi) confidential information contained in research proposals;

(b) Subsection (40)(a) may not be construed to prohibit disclosure of public information required pursuant to Subsection 53B-16-302(2)(a) or (b); and

(c) Subsection (40)(a) may not be construed to affect the ownership of a record;

(41) (a) records in the custody or control of the Office of the Legislative Auditor General that would reveal the name of a particular legislator who requests a legislative audit prior to the date that audit is completed and made public; and

(b) notwithstanding Subsection (41)(a), a request for a legislative audit submitted to the Office of the Legislative Auditor General is a public document unless the legislator asks that the records in the custody or control of the Office of the Legislative Auditor General that would reveal the name of a particular legislator who requests a legislative audit be maintained as protected records until the audit is completed and made public;

(42) records that provide detail as to the location of an explosive, including a map or other document that indicates the location of:

(a) a production facility; or

(b) a magazine;

(43) information:

(a) contained in the statewide database of the Division of Aging and Adult Services created by Section 62A-3-311.1; or

(b) received or maintained in relation to the Identity Theft Reporting Information System (IRIS) established under Section 67-5-22;

(44) information contained in the Licensing Information System described in Title 62A, Chapter 4a, Child and Family Services;

(45) information regarding National Guard operations or activities in support of the National Guard's federal mission;

(46) records provided by any pawn or secondhand business to a law enforcement agency or to the central database in compliance with Title 13, Chapter 32a, Pawnshop and Secondhand Merchandise Transaction Information Act;

(47) information regarding food security, risk, and vulnerability assessments performed by the Department of Agriculture and Food;

(48) except to the extent that the record is exempt from this chapter pursuant to Section 63G-2-106, records related to an emergency plan or program, a copy of which is provided to or prepared or maintained by the Division of Emergency Management, and the disclosure of which would jeopardize:

(a) the safety of the general public; or

(b) the security of:

(i) governmental property;

(ii) governmental programs; or

(iii) the property of a private person who provides the Division of Emergency Management information;

(49) records of the Department of Agriculture and Food that provides for the identification, tracing, or control of livestock diseases, including any program established under Title 4, Chapter 24, Utah Livestock Brand and Anti-Theft Act, or Title 4, Chapter 31, Control of Animal Disease;

(50) as provided in Section 26-39-501:

(a) information or records held by the Department of Health related to a complaint regarding a child care program or residential child care which the department is unable to substantiate; and

(b) information or records related to a complaint received by the Department of Health from an anonymous complainant regarding a child care program or residential child care;

(51) unless otherwise classified as public under Section 63G-2-301 and except as provided under Section 41-1a-116, an individual's home address, home telephone number, or personal mobile phone number, if:

(a) the individual is required to provide the information in order to comply with a law, ordinance, rule, or order of a government entity; and

(b) the subject of the record has a reasonable expectation that this information will be kept confidential due to:

(i) the nature of the law, ordinance, rule, or order; and

(ii) the individual complying with the law, ordinance, rule, or order;

(52) the portion of the following documents that contains a candidate's residential or mailing address, if the candidate provides to the filing officer another address or phone number where the candidate may be contacted:

(a) a declaration of candidacy, a nomination petition, or a certificate of nomination, described in Section 20A-9-201, 20A-9-202, 20A-9-203, 20A-9-404, 20A-9-405, 20A-9-408, 20A-9-408.5, 20A-9-502, or 20A-9-601;

(b) an affidavit of impecuniosity, described in Section 20A-9-201; or

(c) a notice of intent to gather signatures for candidacy, described in Section 20A-9-408;

(53) the name, home address, work addresses, and telephone numbers of an individual that is engaged in, or that provides goods or services for, medical or scientific research that is:

(a) conducted within the state system of higher education, as defined in Section 53B-1-102; and

(b) conducted using animals;

(54) in accordance with Section 78A-12-203, any record of the Judicial Performance Evaluation Commission concerning an individual commissioner's vote on whether or not to recommend that the voters retain a judge including information disclosed under Subsection 78A-12-203(5)(e);

(55) information collected and a report prepared by the Judicial Performance Evaluation Commission concerning a judge, unless Section 20A-7-702 or Title 78A, Chapter 12, Judicial Performance Evaluation Commission Act, requires disclosure of, or makes public, the information or report;

(56) records provided or received by the Public Lands Policy Coordinating Office in furtherance of any contract or other agreement made in accordance with Section 63L-11-202;

(57) information requested by and provided to the 911 Division under Section 63H-7a-302;

(58) in accordance with Section 73-10-33:

(a) a management plan for a water conveyance facility in the possession of the Division of Water Resources or the Board of Water Resources; or

(b) an outline of an emergency response plan in possession of the state or a county or municipality;

(59) the following records in the custody or control of the Office of Inspector General of Medicaid Services, created in Section 63A-13-201:

(a) records that would disclose information relating to allegations of personal misconduct, gross mismanagement, or illegal activity of a person if the information or allegation cannot be corroborated by the Office of Inspector General of Medicaid Services through other documents or evidence, and the records relating to the allegation are not relied

upon by the Office of Inspector General of Medicaid Services in preparing a final investigation report or final audit report;

(b) records and audit workpapers to the extent they would disclose the identity of a person who, during the course of an investigation or audit, communicated the existence of any Medicaid fraud, waste, or abuse, or a violation or suspected violation of a law, rule, or regulation adopted under the laws of this state, a political subdivision of the state, or any recognized entity of the United States, if the information was disclosed on the condition that the identity of the person be protected;

(c) before the time that an investigation or audit is completed and the final investigation or final audit report is released, records or drafts circulated to a person who is not an employee or head of a governmental entity for the person's response or information;

(d) records that would disclose an outline or part of any investigation, audit survey plan, or audit program; or

(e) requests for an investigation or audit, if disclosure would risk circumvention of an investigation or audit;

(60) records that reveal methods used by the Office of Inspector General of Medicaid Services, the fraud unit, or the Department of Health, to discover Medicaid fraud, waste, or abuse;

(61) information provided to the Department of Health or the Division of Occupational and Professional Licensing under Subsections 58-67-304(3) and (4) and Subsections 58-68-304(3) and (4);

(62) a record described in Section 63G-12-210;

(63) captured plate data that is obtained through an automatic license plate reader system used by a governmental entity as authorized in Section 41-6a-2003;

(64) any record in the custody of the Utah Office for Victims of Crime relating to a victim, including:

(a) a victim's application or request for benefits;

(b) a victim's receipt or denial of benefits; and

(c) any administrative notes or records made or created for the purpose of, or used to, evaluate or communicate a victim's eligibility for or denial of benefits from the Crime Victim Reparations Fund;

(65) an audio or video recording created by a body-worn camera, as that term is defined in Section 77-7a-103, that records sound or images inside a hospital or health care facility as those terms are defined in Section 78B-3-403, inside a clinic of a health care provider, as that term is defined in Section 78B-3-403, or inside a human service program as that term is defined in Section 62A-2-101, except for recordings that:

(a) depict the commission of an alleged crime;

(b) record any encounter between a law enforcement officer and a person that results in death or bodily injury, or includes an instance when an officer fires a weapon;

(c) record any encounter that is the subject of a complaint or a legal proceeding against a law enforcement officer or law enforcement agency;

(d) contain an officer involved critical incident as defined in Subsection 76-2-408(1)(f); or

(e) have been requested for reclassification as a public record by a subject or authorized agent of a subject featured in the recording;

(66) a record pertaining to the search process for a president of an institution of higher education described in Section 53B-2-102, except for application materials for a publicly announced finalist;

(67) an audio recording that is:

(a) produced by an audio recording device that is used in conjunction with a device or piece of equipment designed or intended for resuscitating an individual or for treating an individual with a life-threatening condition;

(b) produced during an emergency event when an individual employed to provide law enforcement, fire protection, paramedic, emergency medical, or other first responder service:

(i) is responding to an individual needing resuscitation or with a life-threatening condition; and

(ii) uses a device or piece of equipment designed or intended for resuscitating an individual or for treating an individual with a life-threatening condition; and

(c) intended and used for purposes of training emergency responders how to improve their response to an emergency situation;

(68) records submitted by or prepared in relation to an applicant seeking a recommendation by the Research and General Counsel Subcommittee, the Budget

Subcommittee, or the Audit Subcommittee, established under Section 36-12-8, for an employment position with the Legislature;

(69) work papers as defined in Section 31A-2-204;

(70) a record made available to Adult Protective Services or a law enforcement agency under Section 61-1-206;

(71) a record submitted to the Insurance Department in accordance with Section 31A-37-201;

(72) a record described in Section 31A-37-503;

(73) any record created by the Division of Occupational and Professional Licensing as a result of Subsection 58-37f-304(5) or 58-37f-702(2)(a)(ii);

(74) a record described in Section 72-16-306 that relates to the reporting of an injury involving an amusement ride;

(75) except as provided in Subsection 63G-2-305.5(1), the signature of an individual on a political petition, or on a request to withdraw a signature from a political petition, including a petition or request described in the following titles:

(a) Title 10, Utah Municipal Code;

(b) Title 17, Counties;

(c) Title 17B, Limited Purpose Local Government Entities - Local Districts;

(d) Title 17D, Limited Purpose Local Government Entities - Other Entities; and

(e) Title 20A, Election Code;

(76) except as provided in Subsection 63G-2-305.5(2), the signature of an individual in a voter registration record;

(77) except as provided in Subsection 63G-2-305.5(3), any signature, other than a signature described in Subsection (75) or (76), in the custody of the lieutenant governor or a local political subdivision collected or held under, or in relation to, Title 20A, Election Code;

(78) a Form I-918 Supplement B certification as described in Title 77, Chapter 38, Part 5, Victims Guidelines for Prosecutors Act;

(79) a record submitted to the Insurance Department under Subsection 31A-48-103[~~(1)(b)~~];

(80) personal information, as defined in Section 63G-26-102, to the extent disclosure is prohibited under Section 63G-26-103;

(81) (a) an image taken of an individual during the process of booking the individual into jail, unless:

(i) the individual is convicted of a criminal offense based upon the conduct for which the individual was incarcerated at the time the image was taken;

(ii) a law enforcement agency releases or disseminates the image after determining that:

(A) the individual is a fugitive or an imminent threat to an individual or to public safety; and

(B) releasing or disseminating the image will assist in apprehending the individual or reducing or eliminating the threat; or

(iii) a judge orders the release or dissemination of the image based on a finding that the release or dissemination is in furtherance of a legitimate law enforcement interest[~~.~~];

(82) a record:

(a) concerning an interstate claim to the use of waters in the Colorado River system;

(b) relating to a judicial proceeding, administrative proceeding, or negotiation with a representative from another state or the federal government as provided in Section 63M-14-205; and

(c) the disclosure of which would:

(i) reveal a legal strategy relating to the state's claim to the use of the water in the Colorado River system;

(ii) harm the ability of the Colorado River Authority of Utah or river commissioner to negotiate the best terms and conditions regarding the use of water in the Colorado River system; or

(iii) give an advantage to another state or to the federal government in negotiations regarding the use of water in the Colorado River system; and

(83) any part of an application described in Section 63N-16-201 that the Governor's Office of Economic Opportunity determines is nonpublic, confidential information that if disclosed would result in actual economic harm to the applicant, but this Subsection (83) may not be used to restrict access to a record evidencing a final contract or approval decision.

Section 35. Section **76-6-521** is amended to read:

76-6-521. Fraudulent insurance act.

(1) A person commits a fraudulent insurance act if that person with intent to deceive or defraud:

(a) presents or causes to be presented any oral or written statement or representation knowing that the statement or representation contains false or fraudulent information concerning any fact material to an application for the issuance or renewal of an insurance policy, certificate, or contract, as part of or in support of:

(i) obtaining an insurance policy the insurer would otherwise not issue on the basis of underwriting criteria applicable to the person;

(ii) a scheme or artifice to avoid paying the premium that an insurer charges on the basis of underwriting criteria applicable to the person; or

(iii) a scheme or artifice to file an insurance claim for a loss that has already occurred;

(b) presents, or causes to be presented, any oral or written statement or representation:

(i) (A) as part of or in support of a claim for payment or other benefit pursuant to an insurance policy, certificate, or contract; or

(B) in connection with any civil claim asserted for recovery of damages for personal or bodily injuries or property damage; and

(ii) knowing that the statement or representation contains false, incomplete, or fraudulent information concerning any fact or thing material to the claim;

(c) knowingly accepts a benefit from proceeds derived from a fraudulent insurance act;

(d) intentionally, knowingly, or recklessly devises a scheme or artifice to obtain fees for professional services, or anything of value by means of false or fraudulent pretenses, representations, promises, or material omissions;

(e) knowingly employs, uses, or acts as a runner, as defined in Section 31A-31-102, for the purpose of committing a fraudulent insurance act;

(f) knowingly assists, abets, solicits, or conspires with another to commit a fraudulent insurance act;

(g) knowingly supplies false or fraudulent material information in any document or statement required by the Department of Insurance; or

(h) knowingly fails to forward a premium to an insurer in violation of Section 31A-23a-411.1.

(2) (a) A violation of Subsection (1)(a) (i) is a class A misdemeanor.

(b) A violation of Subsections (1)(a)(ii) or (1)(b) through (1) (h) is punishable as in the manner prescribed by Section 76-10-1801 for communication fraud for property of like value.

(c) A violation of Subsection (1)(a)(iii):

(i) is a class A misdemeanor if the value of the loss is less than $1,500 or unable to be determined; or

(ii) if the value of the loss is $1,500 or more, is punishable as in the manner prescribed by Section 76-10-1801 for communication fraud for property of like value.

(3) A corporation or association is guilty of the offense of insurance fraud under the same conditions as those set forth in Section 76-2-204.

(4) The determination of the degree of any offense under Subsections (1)(a)(ii) and (1)(b) through (1)(h) shall be measured by the total value of all property, money, or other things obtained or sought to be obtained by the fraudulent insurance act or acts described in Subsections (1)(a)(ii) and (1)(b) through (1)(h).

Section 36. **Repealer.**

This bill repeals:

Section **31A-17-519, Small company exemption.**