1 # INSURANCE AMENDMENTS

2 2022 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: James A. Dunnigan**

5 Senate Sponsor: Curtis S. Bramble

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7 **LONG TITLE**

8 **General Description:**

9 This bill amends the Insurance Code.

10 **Highlighted Provisions:**

11 This bill:

12 ▸ amends definitions;

13 ▸ defines terms;

14 ▸ amends provisions related to the Insurance Department's participation in certain

15 national organizations;

16 ▸ modifies provisions regarding Title and Escrow Commission meetings;

17 ▸ modifies provisions regarding an insurer's withdrawal from writing certain lines of

18 insurance;

19 ▸ amends required disclosures for a service contract and vehicle protection product

20 warranty;

21 ▸ enacts provisions related to mutual insurance holding companies;

22 ▸ amends provisions related to the registration of insurers;

23 ▸ requires a large insurance holding company to submit to the Insurance Department a

24 group capital calculation and liquidity stress test results;

25 ▸ amends provisions regarding the standards and management of an insurer within a

26 holding company system;

27 ▸ amends provisions related to the confidentiality of certain information obtained by

28 the Utah Insurance Commissioner (commissioner);

29 ▸ allows an unearned premium reserve fund to be released in accordance with the

30 standards of the National Association of Insurance Commissioners;
31 ▸ amends insurance form requirements;
32 ▸ amends provisions regarding insurance policy renewal notification requirements;
33 ▸ amends provisions related to an arbitration decision's resolution of a claim under an
34 underinsured motorist policy;
35 ▸ amends provisions related to accident and health insurance;
36 ▸ clarifies provisions related to the discontinuance, nonrenewal, or modification of
37 health benefit plans;
38 ▸ clarifies provisions related to standardized health insurance identification cards;
39 ▸ enacts provisions related to health insurance mandates;
40 ▸ enacts provisions related to the renewal, cancellation, and modification of a group
41 accident and health insurance plan;
42 ▸ allows the commissioner to take action against a license of an insurance producer
43 who fails to pay a final judgment rendered against the insurance producer by a court
44 outside of this state;
45 ▸ makes an affiliate of an insolvent insurer subject to Title 31A, Chapter 27a, Insurer
46 Receivership Act;
47 ▸ amends provisions related to a defense to a claim by a receiver;
48 ▸ amends provisions related to a bail bond agency's required financial statements;
49 ▸ amends provisions related to a drug manufacturer's required reports;
50 ▸ modifies the Prescription Drug Price Transparency Act;
51 ▸ amends the criminal offense of fraudulent insurance act; and
52 ▸ makes technical and conforming changes.
53 **Money Appropriated in this Bill:**
54 None
55 **Other Special Clauses:**
56 None
57 **Utah Code Sections Affected:**

58 AMENDS:
59 **26-61a-201**, as last amended by Laws of Utah 2021, Chapters 17 and further amended
60 by Revisor Instructions, Laws of Utah 2021, Chapters 337, 337, and 350
61 **26-61a-204**, as last amended by Laws of Utah 2021, Chapter 350
62 **31A-1-301**, as last amended by Laws of Utah 2021, Second Special Session, Chapter 4
63 **31A-2-210**, as enacted by Laws of Utah 1985, Chapter 242
64 **31A-2-403**, as last amended by Laws of Utah 2020, Chapters 32, 352, and 373
65 **31A-4-115**, as last amended by Laws of Utah 2017, Chapter 292
66 **31A-5-506**, as last amended by Laws of Utah 2007, Chapter 309
67 **31A-6a-104**, as last amended by Laws of Utah 2020, Chapter 32
68 **31A-16-105**, as last amended by Laws of Utah 2017, Chapter 168
69 **31A-16-106**, as last amended by Laws of Utah 2015, Chapter 244
70 **31A-16-109**, as last amended by Laws of Utah 2019, Chapter 193
71 **31A-17-408**, as last amended by Laws of Utah 2001, Chapter 116
72 **31A-17-601**, as last amended by Laws of Utah 2020, Chapter 32
73 **31A-21-201**, as last amended by Laws of Utah 2021, Chapter 252
74 **31A-21-303**, as last amended by Laws of Utah 2020, Chapter 292
75 **31A-22-305.3**, as last amended by Laws of Utah 2020, Chapter 145
76 **31A-22-602**, as last amended by Laws of Utah 2021, Chapter 252
77 **31A-22-618.6**, as last amended by Laws of Utah 2021, Chapter 252
78 **31A-22-618.7**, as last amended by Laws of Utah 2021, Chapter 252
79 **31A-22-618.8**, as last amended by Laws of Utah 2021, Chapter 252
80 **31A-22-627**, as last amended by Laws of Utah 2021, Chapter 252
81 **31A-22-636**, as last amended by Laws of Utah 2011, Chapter 297
82 **31A-23a-111**, as last amended by Laws of Utah 2020, Chapter 32
83 **31A-27a-104**, as last amended by Laws of Utah 2013, Chapter 319
84 **31A-27a-111**, as last amended by Laws of Utah 2018, Chapter 319
85 **31A-30-103**, as last amended by Laws of Utah 2019, Chapter 193

86 **31A-35-404**, as last amended by Laws of Utah 2021, Chapter 252
87 **31A-48-102**, as enacted by Laws of Utah 2020, Chapter 198
88 **31A-48-103**, as last amended by Laws of Utah 2020, Sixth Special Session, Chapter 8
89 **58-13-2.5**, as enacted by Laws of Utah 2009, Chapter 14
90 **63G-2-305**, as last amended by Laws of Utah 2021, Chapters 148, 179, 231, 353, 373,
91 and 382
92 **76-6-521**, as last amended by Laws of Utah 2019, Chapter 193
93 ENACTS:
94 **31A-16-102.6**, Utah Code Annotated 1953
95 **31A-22-657**, Utah Code Annotated 1953
96 **31A-22-727**, Utah Code Annotated 1953
97 REPEALS:
98 **31A-17-519**, as last amended by Laws of Utah 2019, Chapter 193
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100 *Be it enacted by the Legislature of the state of Utah:*
101 Section 1. Section **26-61a-201** is amended to read:
102 **26-61a-201. Medical cannabis patient card -- Medical cannabis guardian card --**
103 **Conditional medical cannabis card -- Application -- Fees -- Studies.**
104 (1) (a) The department shall, within 15 days after the day on which an individual who
105 satisfies the eligibility criteria in this section or Section 26-61a-202 submits an application in
106 accordance with this section or Section 26-61a-202:
107 (i) issue a medical cannabis patient card to an individual described in Subsection
108 (2)(a);
109 (ii) issue a medical cannabis guardian card to an individual described in Subsection
110 (2)(b);
111 (iii) issue a provisional patient card to a minor described in Subsection (2)(c); and
112 (iv) issue a medical cannabis caregiver card to an individual described in Subsection
113 26-61a-202(4).

114 (b) (i) Beginning on the earlier of September 1, 2021, or the date on which the
115 electronic verification system is functionally capable of facilitating a conditional medical
116 cannabis card under this Subsection (1)(b), upon the entry of a recommending medical
117 provider's medical cannabis recommendation for a patient in the state electronic verification
118 system, either by the provider or the provider's employee or by a medical cannabis pharmacy
119 medical provider or medical cannabis pharmacy in accordance with Subsection
120 26-61a-501(11)(a), the department shall issue to the patient an electronic conditional medical
121 cannabis card, in accordance with this Subsection (1)(b).
122 (ii) A conditional medical cannabis card is valid for the lesser of:
123 (A) 60 days; or
124 (B) the day on which the department completes the department's review and issues a
125 medical cannabis card under Subsection (1)(a), denies the patient's medical cannabis card
126 application, or revokes the conditional medical cannabis card under Subsection (8).
127 (iii) The department may issue a conditional medical cannabis card to an individual
128 applying for a medical cannabis patient card for which approval of the Compassionate Use
129 Board is not required.
130 (iv) An individual described in Subsection (1)(b)(iii) has the rights, restrictions, and
131 obligations under law applicable to a holder of the medical cannabis card for which the
132 individual applies and for which the department issues the conditional medical cannabis card.
133 (2) (a) An individual is eligible for a medical cannabis patient card if:
134 (i) (A) the individual is at least 21 years old; or
135 (B) the individual is 18, 19, or 20 years old, the individual petitions the Compassionate
136 Use Board under Section 26-61a-105, and the Compassionate Use Board recommends
137 department approval of the petition;
138 (ii) the individual is a Utah resident;
139 (iii) the individual's recommending medical provider recommends treatment with
140 medical cannabis in accordance with Subsection (4);
141 (iv) the individual signs an acknowledgment stating that the individual received the

142 information described in Subsection (8); and
143 (v) the individual pays to the department a fee in an amount that, subject to Subsection
144 26-61a-109(5), the department sets in accordance with Section 63J-1-504.
145 (b) (i) An individual is eligible for a medical cannabis guardian card if the individual:
146 (A) is at least 18 years old;
147 (B) is a Utah resident;
148 (C) is the parent or legal guardian of a minor for whom the minor's qualified medical
149 provider recommends a medical cannabis treatment, the individual petitions the Compassionate
150 Use Board under Section 26-61a-105, and the Compassionate Use Board recommends
151 department approval of the petition;
152 (D) the individual signs an acknowledgment stating that the individual received the
153 information described in Subsection (9);
154 (E) pays to the department a fee in an amount that, subject to Subsection
155 26-61a-109(5), the department sets in accordance with Section 63J-1-504, plus the cost of the
156 criminal background check described in Section 26-61a-203; and
157 (F) the individual has not been convicted of a misdemeanor or felony drug distribution
158 offense under either state or federal law, unless the individual completed any imposed sentence
159 six months or more before the day on which the individual applies for a medical cannabis
160 guardian card.
161 (ii) The department shall notify the Department of Public Safety of each individual that
162 the department registers for a medical cannabis guardian card.
163 (c) (i) A minor is eligible for a provisional patient card if:
164 (A) the minor has a qualifying condition;
165 (B) the minor's qualified medical provider recommends a medical cannabis treatment
166 to address the minor's qualifying condition;
167 (C) one of the minor's parents or legal guardians petitions the Compassionate Use
168 Board under Section 26-61a-105, and the Compassionate Use Board recommends department
169 approval of the petition; and

170 (D) the minor's parent or legal guardian is eligible for a medical cannabis guardian card
171 under Subsection (2)(b) or designates a caregiver under Subsection (2)(d) who is eligible for a
172 medical cannabis caregiver card under Section 26-61a-202.
173 (ii) The department shall automatically issue a provisional patient card to the minor
174 described in Subsection (2)(c)(i) at the same time the department issues a medical cannabis
175 guardian card to the minor's parent or legal guardian.
176 (d) Beginning on the earlier of September 1, 2021, or the date on which the electronic
177 verification system is functionally capable of servicing the designation, if the parent or legal
178 guardian of a minor described in Subsections (2)(c)(i)(A) through (C) does not qualify for a
179 medical cannabis guardian card under Subsection (2)(b), the parent or legal guardian may
180 designate up to two caregivers in accordance with Subsection 26-61a-202(1)(c) to ensure that
181 the minor has adequate and safe access to the recommended medical cannabis treatment.
182 (3) (a) An individual who is eligible for a medical cannabis card described in
183 Subsection (2)(a) or (b) shall submit an application for a medical cannabis card to the
184 department:
185 (i) through an electronic application connected to the state electronic verification
186 system;
187 (ii) with the recommending medical provider; and
188 (iii) with information including:
189 (A) the applicant's name, gender, age, and address;
190 (B) the number of the applicant's valid form of photo identification;
191 (C) for a medical cannabis guardian card, the name, gender, and age of the minor
192 receiving a medical cannabis treatment under the cardholder's medical cannabis guardian card;
193 and
194 (D) for a provisional patient card, the name of the minor's parent or legal guardian who
195 holds the associated medical cannabis guardian card.
196 (b) The department shall ensure that a medical cannabis card the department issues
197 under this section contains the information described in Subsection (3)(a)(iii).

198 (c) (i) If a recommending medical provider determines that, because of age, illness, or
199 disability, a medical cannabis patient cardholder requires assistance in administering the
200 medical cannabis treatment that the recommending medical provider recommends, the
201 recommending medical provider may indicate the cardholder's need in the state electronic
202 verification system, either directly or, for a limited medical provider, through the order
203 described in Subsections 26-61a-106(1)(c) and (d).
204 (ii) If a recommending medical provider makes the indication described in Subsection
205 (3)(c)(i):
206 (A) the department shall add a label to the relevant medical cannabis patient card
207 indicating the cardholder's need for assistance;
208 (B) any adult who is 18 years old or older and who is physically present with the
209 cardholder at the time the cardholder needs to use the recommended medical cannabis
210 treatment may handle the medical cannabis treatment and any associated medical cannabis
211 device as needed to assist the cardholder in administering the recommended medical cannabis
212 treatment; and
213 (C) an individual of any age who is physically present with the cardholder in the event
214 of an emergency medical condition, as that term is defined in Section [~~31A-22-627~~]
215 31A-1-301, may handle the medical cannabis treatment and any associated medical cannabis
216 device as needed to assist the cardholder in administering the recommended medical cannabis
217 treatment.
218 (iii) A non-cardholding individual acting under Subsection (3)(c)(ii)(B) or (C) may not:
219 (A) ingest or inhale medical cannabis;
220 (B) possess, transport, or handle medical cannabis or a medical cannabis device outside
221 of the immediate area where the cardholder is present or with an intent other than to provide
222 assistance to the cardholder; or
223 (C) possess, transport, or handle medical cannabis or a medical cannabis device when
224 the cardholder is not in the process of being dosed with medical cannabis.
225 (4) To recommend a medical cannabis treatment to a patient or to renew a

226 recommendation, a recommending medical provider shall:
227 (a) before recommending or renewing a recommendation for medical cannabis in a
228 medicinal dosage form or a cannabis product in a medicinal dosage form:
229 (i) verify the patient's and, for a minor patient, the minor patient's parent or legal
230 guardian's valid form of identification described in Subsection (3)(a);
231 (ii) review any record related to the patient and, for a minor patient, the patient's parent
232 or legal guardian in:
233 (A) for a qualified medical provider, the state electronic verification system; and
234 (B) the controlled substance database created in Section 58-37f-201; and
235 (iii) consider the recommendation in light of the patient's qualifying condition and
236 history of medical cannabis and controlled substance use during an initial face-to-face visit
237 with the patient; and
238 (b) state in the recommending medical provider's recommendation that the patient:
239 (i) suffers from a qualifying condition, including the type of qualifying condition; and
240 (ii) may benefit from treatment with cannabis in a medicinal dosage form or a cannabis
241 product in a medicinal dosage form.
242 (5) (a) Except as provided in Subsection (5)(b), a medical cannabis card that the
243 department issues under this section is valid for the lesser of:
244 (i) an amount of time that the recommending medical provider determines; or
245 (ii) (A) six months for the first issuance, and, except as provided in Subsection
246 (5)(a)(ii)(B), for a renewal; or
247 (B) for a renewal, one year if, after at least one year following the issuance of the
248 original medical cannabis card, the recommending medical provider determines that the patient
249 has been stabilized on the medical cannabis treatment and a one-year renewal period is
250 justified.
251 (b) (i) A medical cannabis card that the department issues in relation to a terminal
252 illness described in Section 26-61a-104 does not expire.
253 (ii) The recommending medical provider may revoke a recommendation that the

254 provider made in relation to a terminal illness described in Section 26-61a-104 if the medical
255 cannabis cardholder no longer has the terminal illness.
256 (6) (a) A medical cannabis patient card or a medical cannabis guardian card is
257 renewable if:
258 (i) at the time of renewal, the cardholder meets the requirements of Subsection (2)(a) or
259 (b); or
260 (ii) the cardholder received the medical cannabis card through the recommendation of
261 the Compassionate Use Board under Section 26-61a-105.
262 (b) A cardholder described in Subsection (6)(a) may renew the cardholder's card:
263 (i) using the application process described in Subsection (3); or
264 (ii) through phone or video conference with the recommending medical provider who
265 made the recommendation underlying the card, at the qualifying medical provider's discretion.
266 (c) A cardholder under Subsection (2)(a) or (b) who renews the cardholder's card shall
267 pay to the department a renewal fee in an amount that:
268 (i) subject to Subsection 26-61a-109(5), the department sets in accordance with Section
269 63J-1-504; and
270 (ii) may not exceed the cost of the relatively lower administrative burden of renewal in
271 comparison to the original application process.
272 (d) If a minor meets the requirements of Subsection (2)(c), the minor's provisional
273 patient card renews automatically at the time the minor's parent or legal guardian renews the
274 parent or legal guardian's associated medical cannabis guardian card.
275 (7) (a) A cardholder under this section shall carry the cardholder's valid medical
276 cannabis card with the patient's name.
277 (b) (i) A medical cannabis patient cardholder or a provisional patient cardholder may
278 purchase, in accordance with this chapter and the recommendation underlying the card,
279 cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a
280 medical cannabis device.
281 (ii) A cardholder under this section may possess or transport, in accordance with this

282 chapter and the recommendation underlying the card, cannabis in a medicinal dosage form, a
283 cannabis product in a medicinal dosage form, or a medical cannabis device.
284 (iii) To address the qualifying condition underlying the medical cannabis treatment
285 recommendation:
286 (A) a medical cannabis patient cardholder or a provisional patient cardholder may use
287 cannabis in a medicinal dosage form, a medical cannabis product in a medicinal dosage form,
288 or a medical cannabis device; and
289 (B) a medical cannabis guardian cardholder may assist the associated provisional
290 patient cardholder with the use of cannabis in a medicinal dosage form, a medical cannabis
291 product in a medicinal dosage form, or a medical cannabis device.
292 (c) If a licensed medical cannabis pharmacy is not operating within the state after
293 January 1, 2021, a cardholder under this section:
294 (i) may possess:
295 (A) up to the legal dosage limit of unprocessed cannabis in a medicinal dosage form;
296 (B) up to the legal dosage limit of a cannabis product in a medicinal dosage form; and
297 (C) marijuana drug paraphernalia; and
298 (ii) is not subject to prosecution for the possession described in Subsection (7)(c)(i).
299 (8) The department may revoke a medical cannabis card that the department issues
300 under this section if the cardholder:
301 (a) violates this chapter; or
302 (b) is convicted under state or federal law of:
303 (i) a felony; or
304 (ii) after March 17, 2021, a misdemeanor for drug distribution.
305 (9) The department shall establish by rule, in accordance with Title 63G, Chapter 3,
306 Utah Administrative Rulemaking Act, a process to provide information regarding the following
307 to an individual receiving a medical cannabis card:
308 (a) risks associated with medical cannabis treatment;
309 (b) the fact that a condition's listing as a qualifying condition does not suggest that

310 medical cannabis treatment is an effective treatment or cure for that condition, as described in
311 Subsection 26-61a-104(1); and
312 (c) other relevant warnings and safety information that the department determines.
313 (10) The department may establish procedures by rule, in accordance with Title 63G,
314 Chapter 3, Utah Administrative Rulemaking Act, to implement the application and issuance
315 provisions of this section.
316 (11) (a) On or before September 1, 2021, the department shall establish by rule, in
317 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, a process to allow
318 an individual from another state to register with the department in order to purchase medical
319 cannabis or a medical cannabis device from a medical cannabis pharmacy while the individual
320 is visiting the state.
321 (b) The department may only provide the registration process described in Subsection
322 (11)(a):
323 (i) to a nonresident patient; and
324 (ii) for no more than two visitation periods per calendar year of up to 21 calendar days
325 per visitation period.
326 (12) (a) A person may submit to the department a request to conduct a research study
327 using medical cannabis cardholder data that the state electronic verification system contains.
328 (b) The department shall review a request described in Subsection (12)(a) to determine
329 whether an institutional review board, as that term is defined in Section 26-61-102, could
330 approve the research study.
331 (c) At the time an individual applies for a medical cannabis card, the department shall
332 notify the individual:
333 (i) of how the individual's information will be used as a cardholder;
334 (ii) that by applying for a medical cannabis card, unless the individual withdraws
335 consent under Subsection (12)(d), the individual consents to the use of the individual's
336 information for external research; and
337 (iii) that the individual may withdraw consent for the use of the individual's

338 information for external research at any time, including at the time of application.
339 (d) An applicant may, through the medical cannabis card application, and a medical
340 cannabis cardholder may, through the state central patient portal, withdraw the applicant's or
341 cardholder's consent to participate in external research at any time.
342 (e) The department may release, for the purposes of a study described in this
343 Subsection (12), information about a cardholder under this section who consents to participate
344 under Subsection (12)(c).
345 (f) If an individual withdraws consent under Subsection (12)(d), the withdrawal of
346 consent:
347 (i) applies to external research that is initiated after the withdrawal of consent; and
348 (ii) does not apply to research that was initiated before the withdrawal of consent.
349 (g) The department may establish standards for a medical research study's validity, by
350 rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
351 (13) The department shall record the issuance or revocation of a medical cannabis card
352 under this section in the controlled substance database.
353 Section 2. Section **26-61a-204** is amended to read:
354 **26-61a-204. Medical cannabis card -- Patient and designated caregiver**
355 **requirements -- Rebuttable presumption.**
356 (1) (a) A medical cannabis cardholder who possesses medical cannabis that the
357 cardholder purchased under this chapter:
358 (i) shall carry:
359 (A) at all times the cardholder's medical cannabis card; and
360 (B) after the earlier of January 1, 2021, or the day on which the individual purchases
361 any medical cannabis from a medical cannabis pharmacy, with the medical cannabis, a label
362 that identifies that the medical cannabis was sold from a licensed medical cannabis pharmacy
363 and includes an identification number that links the medical cannabis to the inventory control
364 system; [~~and~~]
365 (ii) may possess up to the legal dosage limit of:

366 (A) unprocessed cannabis in medicinal dosage form; and
367 (B) a cannabis product in medicinal dosage form;
368 (iii) may not possess more medical cannabis than described in Subsection (1)(a)(ii);
369 (iv) may only possess the medical cannabis in the container in which the cardholder
370 received the medical cannabis from the medical cannabis pharmacy; and
371 (v) may not alter or remove any label described in Section 4-41a-602 from the
372 container described in Subsection (1)(a)(iv).
373 (b) Except as provided in Subsection (1)(c) or (e), a medical cannabis cardholder who
374 possesses medical cannabis in violation of Subsection (1)(a) is:
375 (i) guilty of an infraction; and
376 (ii) subject to a $100 fine.
377 (c) A medical cannabis cardholder or a nonresident patient who possesses medical
378 cannabis in an amount that is greater than the legal dosage limit and equal to or less than twice
379 the legal dosage limit is:
380 (i) for a first offense:
381 (A) guilty of an infraction; and
382 (B) subject to a fine of up to $100; and
383 (ii) for a second or subsequent offense:
384 (A) guilty of a class B misdemeanor; and
385 (B) subject to a fine of $1,000.
386 (d) An individual who is guilty of a violation described in Subsection (1)(b) or (c) is
387 not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the
388 conduct underlying the penalty described in Subsection (1)(b) or (c).
389 (e) A nonresident patient who possesses medical cannabis that is not in a medicinal
390 dosage form is:
391 (i) for a first offense:
392 (A) guilty of an infraction; and
393 (B) subject to a fine of up to $100; and

394 (ii) for a second or subsequent offense, is subject to the penalties described in Title 58,
395 Chapter 37, Utah Controlled Substances Act.
396 (f) A medical cannabis cardholder or a nonresident patient who possesses medical
397 cannabis in an amount that is greater than twice the legal dosage limit is subject to the penalties
398 described in Title 58, Chapter 37, Utah Controlled Substances Act.
399 (2) (a) As used in this Subsection (2), "emergency medical condition" means the same
400 as that term is defined in Section [~~31A-22-627~~] 31A-1-301.
401 (b) Except as described in Subsection (2)(c), a medical cannabis patient cardholder, a
402 provisional patient cardholder, or a nonresident patient may not use, in public view, medical
403 cannabis or a cannabis product.
404 (c) In the event of an emergency medical condition, an individual described in
405 Subsection (2)(b) may use, and the holder of a medical cannabis guardian card or a medical
406 cannabis caregiver card may administer to the cardholder's charge, in public view, cannabis in a
407 medicinal dosage form or a cannabis product in a medicinal dosage form.
408 (d) An individual described in Subsection (2)(b) who violates Subsection (2)(b) is:
409 (i) for a first offense:
410 (A) guilty of an infraction; and
411 (B) subject to a fine of up to $100; and
412 (ii) for a second or subsequent offense:
413 (A) guilty of a class B misdemeanor; and
414 (B) subject to a fine of $1,000.
415 (3) If a medical cannabis cardholder carrying the cardholder's card possesses cannabis
416 in a medicinal dosage form or a cannabis product in compliance with Subsection (1), or a
417 medical cannabis device that corresponds with the cannabis or cannabis product:
418 (a) there is a rebuttable presumption that the cardholder possesses the cannabis,
419 cannabis product, or medical cannabis device legally; and
420 (b) there is no probable cause, based solely on the cardholder's possession of the
421 cannabis in medicinal dosage form, cannabis product in medicinal dosage form, or medical

422 cannabis device, to believe that the cardholder is engaging in illegal activity.
423 (4) (a) If a law enforcement officer stops an individual who possesses cannabis in a
424 medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis
425 device, and the individual represents to the law enforcement officer that the individual holds a
426 valid medical cannabis card, but the individual does not have the medical cannabis card in the
427 individual's possession at the time of the stop by the law enforcement officer, the law
428 enforcement officer shall attempt to access the state electronic verification system to determine
429 whether the individual holds a valid medical cannabis card.
430 (b) If the law enforcement officer is able to verify that the individual described in
431 Subsection (4)(a) is a valid medical cannabis cardholder, the law enforcement officer:
432 (i) may not arrest or take the individual into custody for the sole reason that the
433 individual is in possession of cannabis in a medicinal dosage form, a cannabis product in a
434 medicinal dosage form, or a medical cannabis device; and
435 (ii) may not seize the cannabis, cannabis product, or medical cannabis device.
436 Section 3. Section **31A-1-301** is amended to read:
437 **31A-1-301. Definitions.**
438 As used in this title, unless otherwise specified:
439 (1) (a) "Accident and health insurance" means insurance to provide protection against
440 economic losses resulting from:
441 (i) a medical condition including:
442 (A) a medical care expense; or
443 (B) the risk of disability;
444 (ii) accident; or
445 (iii) sickness.
446 (b) "Accident and health insurance":
447 (i) includes a contract with disability contingencies including:
448 (A) an income replacement contract;
449 (B) a health care contract;

450 (C) [~~an expense reimbursement~~] a fixed indemnity contract;
451 (D) a credit accident and health contract;
452 (E) a continuing care contract; and
453 (F) a long-term care contract; and
454 (ii) may provide:
455 (A) hospital coverage;
456 (B) surgical coverage;
457 (C) medical coverage;
458 (D) loss of income coverage;
459 (E) prescription drug coverage;
460 (F) dental coverage; or
461 (G) vision coverage.
462 (c) "Accident and health insurance" does not include workers' compensation insurance.
463 (d) For purposes of a national licensing registry, "accident and health insurance" is the
464 same as "accident and health or sickness insurance."
465 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
466 63G, Chapter 3, Utah Administrative Rulemaking Act.
467 (3) "Administrator" means the same as that term is defined in Subsection [~~(178)~~] (182).
468 (4) "Adult" means an individual who [~~has attained the age of at least 18 years~~] is 18
469 years old or older.
470 (5) "Affiliate" means a person who controls, is controlled by, or is under common
471 control with, another person. A corporation is an affiliate of another corporation, regardless of
472 ownership, if substantially the same group of individuals manage the corporations.
473 (6) "Agency" means:
474 (a) a person other than an individual, including a sole proprietorship by which an
475 individual does business under an assumed name; and
476 (b) an insurance organization licensed or required to be licensed under Section
477 31A-23a-301, 31A-25-207, or 31A-26-209.

478 (7) "Alien insurer" means an insurer domiciled outside the United States.
479 (8) "Amendment" means an endorsement to an insurance policy or certificate.
480 (9) "Annuity" means an agreement to make periodical payments for a period certain or
481 over the lifetime of one or more individuals if the making or continuance of all or some of the
482 series of the payments, or the amount of the payment, is dependent upon the continuance of
483 human life.
484 (10) "Application" means a document:
485 (a) (i) completed by an applicant to provide information about the risk to be insured;
486 and
487 (ii) that contains information that is used by the insurer to evaluate risk and decide
488 whether to:
489 (A) insure the risk under:
490 (I) the coverage as originally offered; or
491 (II) a modification of the coverage as originally offered; or
492 (B) decline to insure the risk; or
493 (b) used by the insurer to gather information from the applicant before issuance of an
494 annuity contract.
495 (11) "Articles" or "articles of incorporation" means:
496 (a) the original articles;
497 (b) a special law;
498 (c) a charter;
499 (d) an amendment;
500 (e) restated articles;
501 (f) articles of merger or consolidation;
502 (g) a trust instrument;
503 (h) another constitutive document for a trust or other entity that is not a corporation;
504 and
505 (i) an amendment to an item listed in Subsections (11)(a) through (h).

506 (12) "Bail bond insurance" means a guarantee that a person will attend court when
507 required, up to and including surrender of the person in execution of a sentence imposed under
508 Subsection 77-20-501(1), as a condition to the release of that person from confinement.
509 (13) "Binder" means the same as that term is defined in Section 31A-21-102.
510 (14) "Blanket insurance policy" or "blanket contract" means a group insurance policy
511 covering a defined class of persons:
512 (a) without individual underwriting or application; and
513 (b) that is determined by definition without designating each person covered.
514 (15) "Board," "board of trustees," or "board of directors" means the group of persons
515 with responsibility over, or management of, a corporation, however designated.
516 (16) "Bona fide office" means a physical office in this state:
517 (a) that is open to the public;
518 (b) that is staffed during regular business hours on regular business days; and
519 (c) at which the public may appear in person to obtain services.
520 (17) "Business entity" means:
521 (a) a corporation;
522 (b) an association;
523 (c) a partnership;
524 (d) a limited liability company;
525 (e) a limited liability partnership; or
526 (f) another legal entity.
527 (18) "Business of insurance" means the same as that term is defined in Subsection
528 [~~(94)~~] (95).
529 (19) "Business plan" means the information required to be supplied to the
530 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
531 when these subsections apply by reference under:
532 (a) Section 31A-8-205; or
533 (b) Subsection 31A-9-205(2).

534 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
535 corporation's affairs, however designated.
536 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a
537 corporation.
538 (21) "Captive insurance company" means:
539 (a) an insurer:
540 (i) owned by a parent organization; and
541 (ii) whose purpose is to insure risks of the parent organization and other risks as
542 authorized under:
543 (A) Chapter 37, Captive Insurance Companies Act; and
544 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; or
545 (b) in the case of a group or association, an insurer:
546 (i) owned by the insureds; and
547 (ii) whose purpose is to insure risks of:
548 (A) a member organization;
549 (B) a group member; or
550 (C) an affiliate of:
551 (I) a member organization; or
552 (II) a group member.
553 (22) "Casualty insurance" means liability insurance.
554 (23) "Certificate" means evidence of insurance given to:
555 (a) an insured under a group insurance policy; or
556 (b) a third party.
557 (24) "Certificate of authority" is included within the term "license."
558 (25) "Claim," unless the context otherwise requires, means a request or demand on an
559 insurer for payment of a benefit according to the terms of an insurance policy.
560 (26) "Claims-made coverage" means an insurance contract or provision limiting
561 coverage under a policy insuring against legal liability to claims that are first made against the

562 insured while the policy is in force.

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

564 commissioner.

565 (b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent

566 supervisory official of another jurisdiction.

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

568 (i) provides board and lodging;

569 (ii) provides one or more of the following:

570 (A) a personal service;

571 (B) a nursing service;

572 (C) a medical service; or

573 (D) any other health-related service; and

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

575 effective:

576 (A) for the life of the insured; or

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

578 (b) Insurance is continuing care insurance regardless of whether or not the board and

579 lodging are provided at the same location as a service described in Subsection (28)(a)(ii).

580 (29) (a) "Control," "controlling," "controlled," or "under common control" means the

581 direct or indirect possession of the power to direct or cause the direction of the management

582 and policies of a person. This control may be:

583 (i) by contract;

584 (ii) by common management;

585 (iii) through the ownership of voting securities; or

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

587 (b) There is no presumption that an individual holding an official position with another

588 person controls that person solely by reason of the position.

589 (c) A person having a contract or arrangement giving control is considered to have

590 control despite the illegality or invalidity of the contract or arrangement.
591 (d) There is a rebuttable presumption of control in a person who directly or indirectly
592 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the
593 voting securities of another person.
594 (30) "Controlled insurer" means a licensed insurer that is either directly or indirectly
595 controlled by a producer.
596 (31) "Controlling person" means a person that directly or indirectly has the power to
597 direct or cause to be directed, the management, control, or activities of a reinsurance
598 intermediary.
599 (32) "Controlling producer" means a producer who directly or indirectly controls an
600 insurer.
601 (33) "Corporate governance annual disclosure" means a report an insurer or insurance
602 group files in accordance with the requirements of Chapter 16b, Corporate Governance Annual
603 Disclosure Act.
604 (34) (a) "Corporation" means an insurance corporation, except when referring to:
605 (i) a corporation doing business:
606 (A) as:
607 (I) an insurance producer;
608 (II) a surplus lines producer;
609 (III) a limited line producer;
610 (IV) a consultant;
611 (V) a managing general agent;
612 (VI) a reinsurance intermediary;
613 (VII) a third party administrator; or
614 (VIII) an adjuster; and
615 (B) under:
616 (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
617 Reinsurance Intermediaries;

618 (II) Chapter 25, Third Party Administrators; or
619 (III) Chapter 26, Insurance Adjusters; or
620 (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance
621 Holding Companies.
622 (b) "Mutual" or "mutual corporation" means a mutual insurance corporation.
623 (c) "Stock corporation" means a stock insurance corporation.
624 (35) (a) "Creditable coverage" has the same meaning as provided in federal regulations
625 adopted pursuant to the Health Insurance Portability and Accountability Act.
626 (b) "Creditable coverage" includes coverage that is offered through a public health plan
627 such as:
628 (i) the Primary Care Network Program under a Medicaid primary care network
629 demonstration waiver obtained subject to Section 26-18-3;
630 (ii) the Children's Health Insurance Program under Section 26-40-106; or
631 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.
632 No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No.
633 109-415.
634 (36) "Credit accident and health insurance" means insurance on a debtor to provide
635 indemnity for payments coming due on a specific loan or other credit transaction while the
636 debtor has a disability.
637 (37) (a) "Credit insurance" means insurance offered in connection with an extension of
638 credit that is limited to partially or wholly extinguishing that credit obligation.
639 (b) "Credit insurance" includes:
640 (i) credit accident and health insurance;
641 (ii) credit life insurance;
642 (iii) credit property insurance;
643 (iv) credit unemployment insurance;
644 (v) guaranteed automobile protection insurance;
645 (vi) involuntary unemployment insurance;

646 (vii) mortgage accident and health insurance;
647 (viii) mortgage guaranty insurance; and
648 (ix) mortgage life insurance.
649 (38) "Credit life insurance" means insurance on the life of a debtor in connection with
650 an extension of credit that pays a person if the debtor dies.
651 (39) "Creditor" means a person, including an insured, having a claim, whether:
652 (a) matured;
653 (b) unmatured;
654 (c) liquidated;
655 (d) unliquidated;
656 (e) secured;
657 (f) unsecured;
658 (g) absolute;
659 (h) fixed; or
660 (i) contingent.
661 (40) "Credit property insurance" means insurance:
662 (a) offered in connection with an extension of credit; and
663 (b) that protects the property until the debt is paid.
664 (41) "Credit unemployment insurance" means insurance:
665 (a) offered in connection with an extension of credit; and
666 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
667 (i) specific loan; or
668 (ii) credit transaction.
669 (42) (a) "Crop insurance" means insurance providing protection against damage to
670 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,
671 disease, or other yield-reducing conditions or perils that is:
672 (i) provided by the private insurance market; or
673 (ii) subsidized by the Federal Crop Insurance Corporation.

674 (b) "Crop insurance" includes multiperil crop insurance.
675 (43) (a) "Customer service representative" means a person that provides an insurance
676 service and insurance product information:
677 (i) for the customer service representative's:
678 (A) producer;
679 (B) surplus lines producer; or
680 (C) consultant employer; and
681 (ii) to the customer service representative's employer's:
682 (A) customer;
683 (B) client; or
684 (C) organization.
685 (b) A customer service representative may only operate within the scope of authority of
686 the customer service representative's producer, surplus lines producer, or consultant employer.
687 (44) "Deadline" means a final date or time:
688 (a) imposed by:
689 (i) statute;
690 (ii) rule; or
691 (iii) order; and
692 (b) by which a required filing or payment must be received by the department.
693 (45) "Deemer clause" means a provision under this title under which upon the
694 occurrence of a condition precedent, the commissioner is considered to have taken a specific
695 action. If the statute so provides, a condition precedent may be the commissioner's failure to
696 take a specific action.
697 (46) "Degree of relationship" means the number of steps between two persons
698 determined by counting the generations separating one person from a common ancestor and
699 then counting the generations to the other person.
700 (47) "Department" means the Insurance Department.
701 (48) "Director" means a member of the board of directors of a corporation.

702 (49) "Disability" means a physiological or psychological condition that partially or
703 totally limits an individual's ability to:
704 (a) perform the duties of:
705 (i) that individual's occupation; or
706 (ii) an occupation for which the individual is reasonably suited by education, training,
707 or experience; or
708 (b) perform two or more of the following basic activities of daily living:
709 (i) eating;
710 (ii) toileting;
711 (iii) transferring;
712 (iv) bathing; or
713 (v) dressing.
714 (50) "Disability income insurance" means the same as that term is defined in
715 Subsection [~~(85)~~] (86).
716 (51) "Domestic insurer" means an insurer organized under the laws of this state.
717 (52) "Domiciliary state" means the state in which an insurer:
718 (a) is incorporated;
719 (b) is organized; or
720 (c) in the case of an alien insurer, enters into the United States.
721 (53) (a) "Eligible employee" means:
722 (i) an employee who:
723 (A) works on a full-time basis; and
724 (B) has a normal work week of 30 or more hours; or
725 (ii) a person described in Subsection (53)(b).
726 (b) "Eligible employee" includes:
727 [~~(i) an owner who:~~]
728 [~~(A) works on a full-time basis;~~]
729 [~~(B) has a normal work week of 30 or more hours; and~~]

730 [~~(C) employs at least one common employee; and~~]
731 [~~(ii) if the individual is included under a health benefit plan of a small employer:~~]
732 [~~(A) a sole proprietor;~~]
733 [~~(B) a partner in a partnership; or~~]
734 [~~(C) an independent contractor.~~]
735 (i) an owner, sole proprietor, or partner who:
736 (A) works on a full-time basis;
737 (B) has a normal work week of 30 or more hours; and
738 (C) employs at least one common employee; and
739 (ii) an independent contractor if the individual is included under a health benefit plan
740 of a small employer.
741 (c) "Eligible employee" does not include, unless eligible under Subsection (53)(b):
742 (i) an individual who works on a temporary or substitute basis for a small employer;
743 (ii) an employer's spouse who does not meet the requirements of Subsection (53)(a)(i);
744 or
745 (iii) a dependent of an employer who does not meet the requirements of Subsection
746 (53)(a)(i).
747 (54) "Emergency medical condition" means a medical condition that:
748 (a) manifests itself by acute symptoms, including severe pain; and
749 (b) would cause a prudent layperson possessing an average knowledge of medicine and
750 health to reasonably expect the absence of immediate medical attention through a hospital
751 emergency department to result in:
752 (i) placing the layperson's health or the layperson's unborn child's health in serious
753 jeopardy;
754 (ii) serious impairment to bodily functions; or
755 (iii) serious dysfunction of any bodily organ or part.
756 [~~(54)~~] (55) "Employee" means:
757 (a) an individual employed by an employer; [~~and~~] or

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

759 [(55)] (56) "Employee benefits" means one or more benefits or services provided to:

760 (a) an employee; or

761 (b) a dependent of an employee.

762 [(56)] (57) (a) "Employee welfare fund" means a fund:

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

764 (A) one or more employers;

765 (B) one or more labor organizations; or

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

767 (ii) that provides employee benefits paid or contracted to be paid, other than income

768 from investments of the fund:

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

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

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

772 revenues.

773 [(57)] (58) "Endorsement" means a written agreement attached to a policy or certificate

774 to modify the policy or certificate coverage.

775 [(58)] (59) (a) "Enrollee" means:

776 (i) a policyholder;

777 (ii) a certificate holder;

778 (iii) a subscriber; or

779 (iv) a covered individual:

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

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

782 (b) "Enrollee" includes an insured.

783 [(59)] (60) "Enrollment date," with respect to a health benefit plan, means:

784 (a) the first day of coverage; or

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

786 [(60)] (61) "Enterprise risk" means an activity, circumstance, event, or series of events
787 involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a
788 material adverse effect upon the financial condition or liquidity of the insurer or its insurance
789 holding company system as a whole, including anything that would cause:
790 (a) the insurer's risk-based capital to fall into an action or control level as set forth in
791 Sections 31A-17-601 through 31A-17-613; or
792 (b) the insurer to be in hazardous financial condition set forth in Section 31A-27a-101.
793 [(61)] (62) (a) "Escrow" means:
794 (i) a transaction that effects the sale, transfer, encumbering, or leasing of real property,
795 when a person not a party to the transaction, and neither having nor acquiring an interest in the
796 title, performs, in accordance with the written instructions or terms of the written agreement
797 between the parties to the transaction, any of the following actions:
798 (A) the explanation, holding, or creation of a document; or
799 (B) the receipt, deposit, and disbursement of money;
800 (ii) a settlement or closing involving:
801 (A) a mobile home;
802 (B) a grazing right;
803 (C) a water right; or
804 (D) other personal property authorized by the commissioner.
805 (b) "Escrow" does not include:
806 (i) the following notarial acts performed by a notary within the state:
807 (A) an acknowledgment;
808 (B) a copy certification;
809 (C) jurat; and
810 (D) an oath or affirmation;
811 (ii) the receipt or delivery of a document; or
812 (iii) the receipt of money for delivery to the escrow agent.
813 [(62)] (63) "Escrow agent" means an agency title insurance producer meeting the

814 requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an
815 individual title insurance producer licensed with an escrow subline of authority.
816 [~~(63)~~] (64) (a) "Excludes" is not exhaustive and does not mean that another thing is not
817 also excluded.
818 (b) The items listed in a list using the term "excludes" are representative examples for
819 use in interpretation of this title.
820 [~~(64)~~] (65) "Exclusion" means for the purposes of accident and health insurance that an
821 insurer does not provide insurance coverage, for whatever reason, for one of the following:
822 (a) a specific physical condition;
823 (b) a specific medical procedure;
824 (c) a specific disease or disorder; or
825 (d) a specific prescription drug or class of prescription drugs.
826 [~~(65) "Expense reimbursement insurance" means insurance:~~]
827 [~~(a) written to provide a payment for an expense relating to hospital confinement~~
828 ~~resulting from illness or injury; and~~]
829 [~~(b) written:~~]
830 [~~(i) as a daily limit for a specific number of days in a hospital; and~~]
831 [~~(ii) to have a one or two day waiting period following a hospitalization.~~]
832 (66) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding
833 a position of public or private trust.
834 (67) (a) "Filed" means that a filing is:
835 (i) submitted to the department as required by and in accordance with applicable
836 statute, rule, or filing order;
837 (ii) received by the department within the time period provided in applicable statute,
838 rule, or filing order; and
839 (iii) accompanied by the appropriate fee in accordance with:
840 (A) Section 31A-3-103; or
841 (B) rule.

842 (b) "Filed" does not include a filing that is rejected by the department because it is not
843 submitted in accordance with Subsection (67)(a).
844 (68) "Filing," when used as a noun, means an item required to be filed with the
845 department including:
846 (a) a policy;
847 (b) a rate;
848 (c) a form;
849 (d) a document;
850 (e) a plan;
851 (f) a manual;
852 (g) an application;
853 (h) a report;
854 (i) a certificate;
855 (j) an endorsement;
856 (k) an actuarial certification;
857 (l) a licensee annual statement;
858 (m) a licensee renewal application;
859 (n) an advertisement;
860 (o) a binder; or
861 (p) an outline of coverage.
862 (69) "First party insurance" means an insurance policy or contract in which the insurer
863 agrees to pay a claim submitted to it by the insured for the insured's losses.
864 (70) (a) "Fixed indemnity insurance" means accident and health insurance written to
865 provide a fixed amount for a specified event relating to or resulting from an illness or injury.
866 (b) "Fixed indemnity insurance" includes hospital confinement indemnity insurance.
867 [~~(70)~~] (71) "Foreign insurer" means an insurer domiciled outside of this state, including
868 an alien insurer.
869 [~~(71)~~] (72) (a) "Form" means one of the following prepared for general use:

870 (i) a policy;
871 (ii) a certificate;
872 (iii) an application;
873 (iv) an outline of coverage; or
874 (v) an endorsement.
875 (b) "Form" does not include a document specially prepared for use in an individual
876 case.
877 [~~(72)~~] (73) "Franchise insurance" means an individual insurance policy provided
878 through a mass marketing arrangement involving a defined class of persons related in some
879 way other than through the purchase of insurance.
880 [~~(73)~~] (74) "General lines of authority" include:
881 (a) the general lines of insurance in Subsection [~~(74)~~] (75);
882 (b) title insurance under one of the following sublines of authority:
883 (i) title examination, including authority to act as a title marketing representative;
884 (ii) escrow, including authority to act as a title marketing representative; and
885 (iii) title marketing representative only;
886 (c) surplus lines;
887 (d) workers' compensation; and
888 (e) another line of insurance that the commissioner considers necessary to recognize in
889 the public interest.
890 [~~(74)~~] (75) "General lines of insurance" include:
891 (a) accident and health;
892 (b) casualty;
893 (c) life;
894 (d) personal lines;
895 (e) property; and
896 (f) variable contracts, including variable life and annuity.
897 [~~(75)~~] (76) "Group health plan" means an employee welfare benefit plan to the extent

898 that the plan provides medical care:
899 (a) (i) to an employee; or
900 (ii) to a dependent of an employee; and
901 (b) (i) directly;
902 (ii) through insurance reimbursement; or
903 (iii) through another method.
904 [~~(76)~~] (77) (a) "Group insurance policy" means a policy covering a group of persons
905 that is issued:
906 (i) to a policyholder on behalf of the group; and
907 (ii) for the benefit of a member of the group who is selected under a procedure defined
908 in:
909 (A) the policy; or
910 (B) an agreement that is collateral to the policy.
911 (b) A group insurance policy may include a member of the policyholder's family or a
912 dependent.
913 [~~(77)~~] (78) "Group-wide supervisor" means the commissioner or other regulatory
914 official designated as the group-wide supervisor for an internationally active insurance group
915 under Section 31A-16-108.6.
916 [~~(78)~~] (79) "Guaranteed automobile protection insurance" means insurance offered in
917 connection with an extension of credit that pays the difference in amount between the
918 insurance settlement and the balance of the loan if the insured automobile is a total loss.
919 [~~(79)~~] (80) (a) "Health benefit plan" means[~~, except as provided in Subsection (79)(b),~~]
920 a policy, contract, certificate, or agreement offered or issued by [~~a health carrier~~] an insurer to
921 provide, deliver, arrange for, pay for, or reimburse any of the costs of health care, including
922 major medical expense coverage.
923 (b) "Health benefit plan" does not include:
924 (i) coverage only for accident or disability income insurance, or any combination
925 thereof;

926 (ii) coverage issued as a supplement to liability insurance;
927 (iii) liability insurance, including general liability insurance and automobile liability
928 insurance;
929 (iv) workers' compensation or similar insurance;
930 (v) automobile medical payment insurance;
931 (vi) credit-only insurance;
932 (vii) coverage for on-site medical clinics;
933 (viii) other similar insurance coverage, specified in federal regulations issued pursuant
934 to Pub. L. No. 104-191, under which benefits for health care services are secondary or
935 incidental to other insurance benefits;
936 (ix) the following benefits if they are provided under a separate policy, certificate, or
937 contract of insurance or are otherwise not an integral part of the plan:
938 (A) limited scope dental or vision benefits;
939 (B) benefits for long-term care, nursing home care, home health care,
940 community-based care, or any combination thereof; or
941 (C) other similar limited benefits, specified in federal regulations issued pursuant to
942 Pub. L. No. 104-191;
943 (x) the following benefits if the benefits are provided under a separate policy,
944 certificate, or contract of insurance, there is no coordination between the provision of benefits
945 and any exclusion of benefits under any health plan, and the benefits are paid with respect to an
946 event without regard to whether benefits are provided under any health plan:
947 (A) coverage only for specified disease or illness; or
948 (B) [~~hospital indemnity or other~~] fixed indemnity insurance;
949 (xi) the following if offered as a separate policy, certificate, or contract of insurance:
950 (A) Medicare supplemental health insurance as defined under the Social Security Act,
951 42 U.S.C. Sec. 1395ss(g)(1);
952 (B) coverage supplemental to the coverage provided under United States Code, Title
953 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services

954 (CHAMPUS); or

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

956 plan;

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

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

959 [~~(80)~~] (81) "Health care" means any of the following intended for use in the diagnosis,

960 treatment, mitigation, or prevention of a human ailment or impairment:

961 (a) a professional service;

962 (b) a personal service;

963 (c) a facility;

964 (d) equipment;

965 (e) a device;

966 (f) supplies; or

967 (g) medicine.

968 [~~(81)~~] (82) (a) "Health care insurance" or "health insurance" means insurance

969 providing:

970 (i) a health care benefit; or

971 (ii) payment of an incurred health care expense.

972 (b) "Health care insurance" or "health insurance" does not include accident and health

973 insurance providing a benefit for:

974 (i) replacement of income;

975 (ii) short-term accident;

976 (iii) fixed indemnity;

977 (iv) credit accident and health;

978 (v) supplements to liability;

979 (vi) workers' compensation;

980 (vii) automobile medical payment;

981 (viii) no-fault automobile;

982 (ix) equivalent self-insurance; or

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

984 another type of policy.

985 [(82)] (83) "Health care provider" means the same as that term is defined in Section

986 78B-3-403.

987 [(83)] (84) "Health insurance exchange" means an exchange as defined in 45 C.F.R.

988 Sec. 155.20.

989 [(84)] (85) "Health Insurance Portability and Accountability Act" means the Health

990 Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as

991 amended.

992 [(85)] (86) "Income replacement insurance" or "disability income insurance" means

993 insurance written to provide payments to replace income lost from accident or sickness.

994 [(86)] (87) "Indemnity" means the payment of an amount to offset all or part of an

995 insured loss.

996 [(87)] (88) "Independent adjuster" means an insurance adjuster required to be licensed

997 under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

998 [(88)] (89) "Independently procured insurance" means insurance procured under

999 Section 31A-15-104.

1000 [(89)] (90) "Individual" means a natural person.

1001 [(90)] (91) "Inland marine insurance" includes insurance covering:

1002 (a) property in transit on or over land;

1003 (b) property in transit over water by means other than boat or ship;

1004 (c) bailee liability;

1005 (d) fixed transportation property such as bridges, electric transmission systems, radio

1006 and television transmission towers and tunnels; and

1007 (e) personal and commercial property floaters.

1008 [(91)] (92) "Insolvency" or "insolvent" means that:

1009 (a) an insurer is unable to pay the insurer's obligations as the obligations are due;

1010 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
1011 RBC under Subsection 31A-17-601(8)(c); or
1012 (c) an insurer's admitted assets are less than the insurer's liabilities.
1013 [(92)] (93) (a) "Insurance" means:
1014 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
1015 persons to one or more other persons; or
1016 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
1017 group of persons that includes the person seeking to distribute that person's risk.
1018 (b) "Insurance" includes:
1019 (i) a risk distributing arrangement providing for compensation or replacement for
1020 damages or loss through the provision of a service or a benefit in kind;
1021 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a
1022 business and not as merely incidental to a business transaction; and
1023 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,
1024 but with a class of persons who have agreed to share the risk.
1025 [(93)] (94) "Insurance adjuster" means a person who directs or conducts the
1026 investigation, negotiation, or settlement of a claim under an insurance policy other than life
1027 insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance
1028 policy.
1029 [(94)] (95) "Insurance business" or "business of insurance" includes:
1030 (a) providing health care insurance by an organization that is or is required to be
1031 licensed under this title;
1032 (b) providing a benefit to an employee in the event of a contingency not within the
1033 control of the employee, in which the employee is entitled to the benefit as a right, which
1034 benefit may be provided either:
1035 (i) by a single employer or by multiple employer groups; or
1036 (ii) through one or more trusts, associations, or other entities;
1037 (c) providing an annuity:

1038 (i) including an annuity issued in return for a gift; and

1039 (ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2)

1040 and (3);

1041 (d) providing the characteristic services of a motor club [as outlined in Subsection

1042 (125)];

1043 (e) providing another person with insurance;

1044 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,

1045 or surety, a contract or policy offering title insurance;

1046 (g) transacting or proposing to transact any phase of title insurance, including:

1047 (i) solicitation;

1048 (ii) negotiation preliminary to execution;

1049 (iii) execution of a contract of title insurance;

1050 (iv) insuring; and

1051 (v) transacting matters subsequent to the execution of the contract and arising out of

1052 the contract, including reinsurance;

1053 (h) transacting or proposing a life settlement; and

1054 (i) doing, or proposing to do, any business in substance equivalent to Subsections

1055 [(94)] (95)(a) through (h) in a manner designed to evade this title.

1056 [(95)] (96) "Insurance consultant" or "consultant" means a person who:

1057 (a) advises another person about insurance needs and coverages;

1058 (b) is compensated by the person advised on a basis not directly related to the insurance

1059 placed; and

1060 (c) except as provided in Section 31A-23a-501, is not compensated directly or

1061 indirectly by an insurer or producer for advice given.

1062 [(96)] (97) "Insurance group" means the persons that comprise an insurance holding

1063 company system.

1064 [(97)] (98) "Insurance holding company system" means a group of two or more

1065 affiliated persons, at least one of whom is an insurer.

1066 [(98)] (99) (a) "Insurance producer" or "producer" means a person licensed or required
1067 to be licensed under the laws of this state to sell, solicit, or negotiate insurance.
1068 (b) (i) "Producer for the insurer" means a producer who is compensated directly or
1069 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that
1070 insurer.
1071 (ii) "Producer for the insurer" may be referred to as an "agent."
1072 (c) (i) "Producer for the insured" means a producer who:
1073 (A) is compensated directly and only by an insurance customer or an insured; and
1074 (B) receives no compensation directly or indirectly from an insurer for selling,
1075 soliciting, or negotiating an insurance product of that insurer to an insurance customer or
1076 insured.
1077 (ii) "Producer for the insured" may be referred to as a "broker."
1078 [(99)] (100) (a) "Insured" means a person to whom or for whose benefit an insurer
1079 makes a promise in an insurance policy and includes:
1080 (i) a policyholder;
1081 (ii) a subscriber;
1082 (iii) a member; and
1083 (iv) a beneficiary.
1084 (b) The definition in Subsection [(99)] (100)(a):
1085 (i) applies only to this title;
1086 (ii) does not define the meaning of "insured" as used in an insurance policy or
1087 certificate; and
1088 (iii) includes an enrollee.
1089 [(100)] (101) (a) "Insurer," "carrier," "insurance carrier," or "insurance company"
1090 means a person doing an insurance business as a principal including:
1091 (i) a fraternal benefit society;
1092 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
1093 31A-22-1305(2) and (3);

1094 (iii) a motor club;
1095 (iv) an employee welfare plan;
1096 (v) a person purporting or intending to do an insurance business as a principal on that
1097 person's own account; and
1098 (vi) a health maintenance organization.
1099 (b) "Insurer," "carrier," "insurance carrier," or "insurance company" does not include a
1100 governmental entity.
1101 [(101)] (102) "Interinsurance exchange" means the same as that term is defined in
1102 Subsection [(160)] (163).
1103 [(102)] (103) "Internationally active insurance group" means an insurance holding
1104 company system:
1105 (a) that includes an insurer registered under Section 31A-16-105;
1106 (b) that has premiums written in at least three countries;
1107 (c) whose percentage of gross premiums written outside the United States is at least
1108 10% of its total gross written premiums; and
1109 (d) that, based on a three-year rolling average, has:
1110 (i) total assets of at least $50,000,000,000; or
1111 (ii) total gross written premiums of at least $10,000,000,000.
1112 [(103)] (104) "Involuntary unemployment insurance" means insurance:
1113 (a) offered in connection with an extension of credit; and
1114 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
1115 coming due on a:
1116 (i) specific loan; or
1117 (ii) credit transaction.
1118 [(104)] (105) "Large employer," in connection with a health benefit plan, means an
1119 employer who, with respect to a calendar year and to a plan year:
1120 (a) employed an average of at least 51 employees on business days during the
1121 preceding calendar year; and

1122 (b) employs at least one employee on the first day of the plan year.

1123 [(105)] (106) "Late enrollee," with respect to an employer health benefit plan, means

1124 an individual whose enrollment is a late enrollment.

1125 [(106)] (107) "Late enrollment," with respect to an employer health benefit plan, means

1126 enrollment of an individual other than:

1127 (a) on the earliest date on which coverage can become effective for the individual

1128 under the terms of the plan; or

1129 (b) through special enrollment.

1130 [(107)] (108) (a) Except for a retainer contract or legal assistance described in Section

1131 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a

1132 specified legal expense.

1133 (b) "Legal expense insurance" includes an arrangement that creates a reasonable

1134 expectation of an enforceable right.

1135 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,

1136 legal services incidental to other insurance coverage.

1137 [(108)] (109) (a) "Liability insurance" means insurance against liability:

1138 (i) for death, injury, or disability of a human being, or for damage to property,

1139 exclusive of the coverages under:

1140 (A) medical malpractice insurance;

1141 (B) professional liability insurance; and

1142 (C) workers' compensation insurance;

1143 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the

1144 insured who is injured, irrespective of legal liability of the insured, when issued with or

1145 supplemental to insurance against legal liability for the death, injury, or disability of a human

1146 being, exclusive of the coverages under:

1147 (A) medical malpractice insurance;

1148 (B) professional liability insurance; and

1149 (C) workers' compensation insurance;

1150 (iii) for loss or damage to property resulting from an accident to or explosion of a
1151 boiler, pipe, pressure container, machinery, or apparatus;
1152 (iv) for loss or damage to property caused by:
1153 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
1154 (B) water entering through a leak or opening in a building; or
1155 (v) for other loss or damage properly the subject of insurance not within another kind
1156 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.
1157 (b) "Liability insurance" includes:
1158 (i) vehicle liability insurance;
1159 (ii) residential dwelling liability insurance; and
1160 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
1161 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
1162 elevator, boiler, machinery, or apparatus.
1163 [~~(109)~~] (110) (a) "License" means authorization issued by the commissioner to engage
1164 in an activity that is part of or related to the insurance business.
1165 (b) "License" includes a certificate of authority issued to an insurer.
1166 [~~(110)~~] (111) (a) "Life insurance" means:
1167 (i) insurance on a human life; and
1168 (ii) insurance pertaining to or connected with human life.
1169 (b) The business of life insurance includes:
1170 (i) granting a death benefit;
1171 (ii) granting an annuity benefit;
1172 (iii) granting an endowment benefit;
1173 (iv) granting an additional benefit in the event of death by accident;
1174 (v) granting an additional benefit to safeguard the policy against lapse; and
1175 (vi) providing an optional method of settlement of proceeds.
1176 [~~(111)~~] (112) "Limited license" means a license that:
1177 (a) is issued for a specific product of insurance; and

1178 (b) limits an individual or agency to transact only for that product or insurance.

1179 [~~(112)~~] (113) "Limited line credit insurance" includes the following forms of

1180 insurance:

1181 (a) credit life;

1182 (b) credit accident and health;

1183 (c) credit property;

1184 (d) credit unemployment;

1185 (e) involuntary unemployment;

1186 (f) mortgage life;

1187 (g) mortgage guaranty;

1188 (h) mortgage accident and health;

1189 (i) guaranteed automobile protection; and

1190 (j) another form of insurance offered in connection with an extension of credit that:

1191 (i) is limited to partially or wholly extinguishing the credit obligation; and

1192 (ii) the commissioner determines by rule should be designated as a form of limited line

1193 credit insurance.

1194 [~~(113)~~] (114) "Limited line credit insurance producer" means a person who sells,

1195 solicits, or negotiates one or more forms of limited line credit insurance coverage to an

1196 individual through a master, corporate, group, or individual policy.

1197 [~~(114)~~] (115) "Limited line insurance" includes:

1198 (a) bail bond;

1199 (b) limited line credit insurance;

1200 (c) legal expense insurance;

1201 (d) motor club insurance;

1202 (e) car rental related insurance;

1203 (f) travel insurance;

1204 (g) crop insurance;

1205 (h) self-service storage insurance;

1206 (i) guaranteed asset protection waiver;

1207 (j) portable electronics insurance; and

1208 (k) another form of limited insurance that the commissioner determines by rule should

1209 be designated a form of limited line insurance.

1210 [~~(115)~~] (116) "Limited lines authority" includes the lines of insurance listed in

1211 Subsection [~~(114)~~] (115).

1212 [~~(116)~~] (117) "Limited lines producer" means a person who sells, solicits, or negotiates

1213 limited lines insurance.

1214 [~~(117)~~] (118) (a) "Long-term care insurance" means an insurance policy or rider

1215 advertised, marketed, offered, or designated to provide coverage:

1216 (i) in a setting other than an acute care unit of a hospital;

1217 (ii) for not less than 12 consecutive months for a covered person on the basis of:

1218 (A) expenses incurred;

1219 (B) indemnity;

1220 (C) prepayment; or

1221 (D) another method;

1222 (iii) for one or more necessary or medically necessary services that are:

1223 (A) diagnostic;

1224 (B) preventative;

1225 (C) therapeutic;

1226 (D) rehabilitative;

1227 (E) maintenance; or

1228 (F) personal care; and

1229 (iv) that may be issued by:

1230 (A) an insurer;

1231 (B) a fraternal benefit society;

1232 (C) (I) a nonprofit health hospital; and

1233 (II) a medical service corporation;

1234 (D) a prepaid health plan;
1235 (E) a health maintenance organization; or
1236 (F) an entity similar to the entities described in Subsections [(117)] (118)(a)(iv)(A)
1237 through (E) to the extent that the entity is otherwise authorized to issue life or health care
1238 insurance.
1239 (b) "Long-term care insurance" includes:
1240 (i) any of the following that provide directly or supplement long-term care insurance:
1241 (A) a group or individual annuity or rider; or
1242 (B) a life insurance policy or rider;
1243 (ii) a policy or rider that provides for payment of benefits on the basis of:
1244 (A) cognitive impairment; or
1245 (B) functional capacity; or
1246 (iii) a qualified long-term care insurance contract.
1247 (c) "Long-term care insurance" does not include:
1248 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
1249 (ii) basic hospital expense coverage;
1250 (iii) basic medical/surgical expense coverage;
1251 (iv) hospital confinement indemnity coverage;
1252 (v) major medical expense coverage;
1253 (vi) income replacement or related asset-protection coverage;
1254 (vii) accident only coverage;
1255 (viii) coverage for a specified:
1256 (A) disease; or
1257 (B) accident;
1258 (ix) limited benefit health coverage; [or]
1259 (x) a life insurance policy that accelerates the death benefit to provide the option of a
1260 lump sum payment:
1261 (A) if the following are not conditioned on the receipt of long-term care:

1262 (I) benefits; or
1263 (II) eligibility; and
1264 (B) the coverage is for one or more the following qualifying events:
1265 (I) terminal illness;
1266 (II) medical conditions requiring extraordinary medical intervention; or
1267 (III) permanent institutional confinement[.]; or
1268 (xi) limited long-term care as defined in Section 31A-22-2002.
1269 [(118)] (119) "Managed care organization" means a person:
1270 (a) licensed as a health maintenance organization under Chapter 8, Health Maintenance
1271 Organizations and Limited Health Plans; or
1272 (b) (i) licensed under:
1273 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1274 (B) Chapter 7, Nonprofit Health Service Insurance Corporations; or
1275 (C) Chapter 14, Foreign Insurers; and
1276 (ii) that requires an enrollee to use, or offers incentives, including financial incentives,
1277 for an enrollee to use, network providers.
1278 [(119)] (120) "Medical malpractice insurance" means insurance against legal liability
1279 incident to the practice and provision of a medical service other than the practice and provision
1280 of a dental service.
1281 [(120)] (121) "Member" means a person having membership rights in an insurance
1282 corporation.
1283 [(121)] (122) "Minimum capital" or "minimum required capital" means the capital that
1284 must be constantly maintained by a stock insurance corporation as required by statute.
1285 [(122)] (123) "Mortgage accident and health insurance" means insurance offered in
1286 connection with an extension of credit that provides indemnity for payments coming due on a
1287 mortgage while the debtor has a disability.
1288 [(123)] (124) "Mortgage guaranty insurance" means surety insurance under which a
1289 mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

1290 [(124)] (125) "Mortgage life insurance" means insurance on the life of a debtor in
1291 connection with an extension of credit that pays if the debtor dies.
1292 [(125)] (126) "Motor club" means a person:
1293 (a) licensed under:
1294 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1295 (ii) Chapter 11, Motor Clubs; or
1296 (iii) Chapter 14, Foreign Insurers; and
1297 (b) that promises for an advance consideration to provide for a stated period of time
1298 one or more:
1299 (i) legal services under Subsection 31A-11-102(1)(b);
1300 (ii) bail services under Subsection 31A-11-102(1)(c); or
1301 (iii) (A) trip reimbursement;
1302 (B) towing services;
1303 (C) emergency road services;
1304 (D) stolen automobile services;
1305 (E) a combination of the services listed in Subsections [(125)] (126)(b)(iii)(A) through
1306 (D); or
1307 (F) other services given in Subsections 31A-11-102(1)(b) through (f).
1308 [(126)] (127) "Mutual" means a mutual insurance corporation.
1309 (128) "NAIC" means the National Association of Insurance Commissioners.
1310 (129) "NAIC liquidity stress test framework" means a NAIC publication that includes:
1311 (a) a history of the NAIC's development of regulatory liquidity stress testing;
1312 (b) the scope criteria applicable for a specific data year; and
1313 (c) the liquidity stress test instructions and reporting templates for a specific data year,
1314 as adopted by the NAIC and as amended by the NAIC in accordance with NAIC procedures.
1315 [(127)] (130) "Network plan" means health care insurance:
1316 (a) that is issued by an insurer; and
1317 (b) under which the financing and delivery of medical care is provided, in whole or in

1318 part, through a defined set of providers under contract with the insurer, including the financing
1319 and delivery of an item paid for as medical care.
1320 [~~(128)~~] (131) "Network provider" means a health care provider who has an agreement
1321 with a managed care organization to provide health care services to an enrollee with an
1322 expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly
1323 from the managed care organization.
1324 [~~(129)~~] (132) "Nonparticipating" means a plan of insurance under which the insured is
1325 not entitled to receive a dividend representing a share of the surplus of the insurer.
1326 [~~(130)~~] (133) "Ocean marine insurance" means insurance against loss of or damage to:
1327 (a) ships or hulls of ships;
1328 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,
1329 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia
1330 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;
1331 (c) earnings such as freight, passage money, commissions, or profits derived from
1332 transporting goods or people upon or across the oceans or inland waterways; or
1333 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
1334 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons
1335 in connection with maritime activity.
1336 [~~(131)~~] (134) "Order" means an order of the commissioner.
1337 [~~(132)~~] (135) "ORSA guidance manual" means the current version of the Own Risk
1338 and Solvency Assessment Guidance Manual developed and adopted by the National
1339 Association of Insurance Commissioners and as amended from time to time.
1340 [~~(133)~~] (136) "ORSA summary report" means a confidential high-level summary of an
1341 insurer or insurance group's own risk and solvency assessment.
1342 [~~(134)~~] (137) "Outline of coverage" means a summary that explains an accident and
1343 health insurance policy.
1344 [~~(135)~~] (138) "Own risk and solvency assessment" means an insurer or insurance
1345 group's confidential internal assessment:

1346 (a) (i) of each material and relevant risk associated with the insurer or insurance group;
1347 (ii) of the insurer or insurance group's current business plan to support each risk
1348 described in Subsection [~~(135)~~] (138)(a)(i); and
1349 (iii) of the sufficiency of capital resources to support each risk described in Subsection
1350 [~~(135)~~] (138)(a)(i); and
1351 (b) that is appropriate to the nature, scale, and complexity of an insurer or insurance
1352 group.
1353 [~~(136)~~] (139) "Participating" means a plan of insurance under which the insured is
1354 entitled to receive a dividend representing a share of the surplus of the insurer.
1355 [~~(137)~~] (140) "Participation," as used in a health benefit plan, means a requirement
1356 relating to the minimum percentage of eligible employees that must be enrolled in relation to
1357 the total number of eligible employees of an employer reduced by each eligible employee who
1358 voluntarily declines coverage under the plan because the employee:
1359 (a) has other group health care insurance coverage; or
1360 (b) receives:
1361 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social
1362 Security Amendments of 1965; or
1363 (ii) another government health benefit.
1364 [~~(138)~~] (141) "Person" includes:
1365 (a) an individual;
1366 (b) a partnership;
1367 (c) a corporation;
1368 (d) an incorporated or unincorporated association;
1369 (e) a joint stock company;
1370 (f) a trust;
1371 (g) a limited liability company;
1372 (h) a reciprocal;
1373 (i) a syndicate; or

1374 (j) another similar entity or combination of entities acting in concert.

1375 [~~(139)~~] (142) "Personal lines insurance" means property and casualty insurance

1376 coverage sold for primarily noncommercial purposes to:

1377 (a) an individual; or

1378 (b) a family.

1379 [~~(140)~~] (143) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec.

1380 1002(16)(B).

1381 [~~(141)~~] (144) "Plan year" means:

1382 (a) the year that is designated as the plan year in:

1383 (i) the plan document of a group health plan; or

1384 (ii) a summary plan description of a group health plan;

1385 (b) if the plan document or summary plan description does not designate a plan year or

1386 there is no plan document or summary plan description:

1387 (i) the year used to determine deductibles or limits;

1388 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;

1389 or

1390 (iii) the employer's taxable year if:

1391 (A) the plan does not impose deductibles or limits on a yearly basis; and

1392 (B) (I) the plan is not insured; or

1393 (II) the insurance policy is not renewed on an annual basis; or

1394 (c) in a case not described in Subsection [~~(141)~~] (144)(a) or (b), the calendar year.

1395 [~~(142)~~] (145) (a) "Policy" means a document, including an attached endorsement or

1396 application that:

1397 (i) purports to be an enforceable contract; and

1398 (ii) memorializes in writing some or all of the terms of an insurance contract.

1399 (b) "Policy" includes a service contract issued by:

1400 (i) a motor club under Chapter 11, Motor Clubs;

1401 (ii) a service contract provided under Chapter 6a, Service Contracts; and

1402 (iii) a corporation licensed under:
1403 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
1404 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
1405 (c) "Policy" does not include:
1406 (i) a certificate under a group insurance contract; or
1407 (ii) a document that does not purport to have legal effect.
1408 [~~(143)~~] (146) "Policyholder" means a person who controls a policy, binder, or oral
1409 contract by ownership, premium payment, or otherwise.
1410 [~~(144)~~] (147) "Policy illustration" means a presentation or depiction that includes
1411 nonguaranteed elements of a policy offering life insurance over a period of years.
1412 [~~(145)~~] (148) "Policy summary" means a synopsis describing the elements of a life
1413 insurance policy.
1414 [~~(146)~~] (149) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L.
1415 No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152,
1416 and related federal regulations and guidance.
1417 [~~(147)~~] (150) "Preexisting condition," with respect to health care insurance:
1418 (a) means a condition that was present before the effective date of coverage, whether or
1419 not medical advice, diagnosis, care, or treatment was recommended or received before that day;
1420 and
1421 (b) does not include a condition indicated by genetic information unless an actual
1422 diagnosis of the condition by a physician has been made.
1423 [~~(148)~~] (151) (a) "Premium" means the monetary consideration for an insurance policy.
1424 (b) "Premium" includes, however designated:
1425 (i) an assessment;
1426 (ii) a membership fee;
1427 (iii) a required contribution; or
1428 (iv) monetary consideration.
1429 (c) (i) "Premium" does not include consideration paid to a third party administrator for

1430 the third party administrator's services.
1431 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for
1432 insurance on the risks administered by the third party administrator.
1433 [~~(149)~~] (152) "Principal officers" for a corporation means the officers designated under
1434 Subsection 31A-5-203(3).
1435 [~~(150)~~] (153) "Proceeding" includes an action or special statutory proceeding.
1436 [~~(151)~~] (154) "Professional liability insurance" means insurance against legal liability
1437 incident to the practice of a profession and provision of a professional service.
1438 [~~(152)~~] (155) (a) [~~Except as provided in Subsection (152)(b), "property~~] "Property
1439 insurance" means insurance against loss or damage to real or personal property of every kind
1440 and any interest in that property:
1441 (i) from all hazards or causes; and
1442 (ii) against loss consequential upon the loss or damage including vehicle
1443 comprehensive and vehicle physical damage coverages.
1444 (b) "Property insurance" does not include:
1445 (i) inland marine insurance; and
1446 (ii) ocean marine insurance.
1447 [~~(153)~~] (156) "Qualified long-term care insurance contract" or "federally tax qualified
1448 long-term care insurance contract" means:
1449 (a) an individual or group insurance contract that meets the requirements of Section
1450 7702B(b), Internal Revenue Code; or
1451 (b) the portion of a life insurance contract that provides long-term care insurance:
1452 (i) (A) by rider; or
1453 (B) as a part of the contract; and
1454 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue
1455 Code.
1456 [~~(154)~~] (157) "Qualified United States financial institution" means an institution that:
1457 (a) is:

1458 (i) organized under the laws of the United States or any state; or
1459 (ii) in the case of a United States office of a foreign banking organization, licensed
1460 under the laws of the United States or any state;
1461 (b) is regulated, supervised, and examined by a United States federal or state authority
1462 having regulatory authority over a bank or trust company; and
1463 (c) meets the standards of financial condition and standing that are considered
1464 necessary and appropriate to regulate the quality of a financial institution whose letters of credit
1465 will be acceptable to the commissioner as determined by:
1466 (i) the commissioner by rule; or
1467 (ii) the Securities Valuation Office of the National Association of Insurance
1468 Commissioners.
1469 [(155)] (158) (a) "Rate" means:
1470 (i) the cost of a given unit of insurance; or
1471 (ii) for property or casualty insurance, that cost of insurance per exposure unit either
1472 expressed as:
1473 (A) a single number; or
1474 (B) a pure premium rate, adjusted before the application of individual risk variations
1475 based on loss or expense considerations to account for the treatment of:
1476 (I) expenses;
1477 (II) profit; and
1478 (III) individual insurer variation in loss experience.
1479 (b) "Rate" does not include a minimum premium.
1480 [(156)] (159) (a) [Except as provided in Subsection (156)(b), "rate] "Rate service
1481 organization" means a person who assists an insurer in rate making or filing by:
1482 (i) collecting, compiling, and furnishing loss or expense statistics;
1483 (ii) recommending, making, or filing rates or supplementary rate information; or
1484 (iii) advising about rate questions, except as an attorney giving legal advice.
1485 (b) "Rate service organization" does not [mean] include:

1486 (i) an employee of an insurer;
1487 (ii) a single insurer or group of insurers under common control;
1488 (iii) a joint underwriting group; or
1489 (iv) an individual serving as an actuarial or legal consultant.
1490 [~~(157)~~] (160) "Rating manual" means any of the following used to determine initial and
1491 renewal policy premiums:
1492 (a) a manual of rates;
1493 (b) a classification;
1494 (c) a rate-related underwriting rule; and
1495 (d) a rating formula that describes steps, policies, and procedures for determining
1496 initial and renewal policy premiums.
1497 [~~(158)~~] (161) (a) "Rebate" means a licensee paying, allowing, giving, or offering to
1498 pay, allow, or give, directly or indirectly:
1499 (i) a refund of premium or portion of premium;
1500 (ii) a refund of commission or portion of commission;
1501 (iii) a refund of all or a portion of a consultant fee; or
1502 (iv) providing services or other benefits not specified in an insurance or annuity
1503 contract.
1504 (b) "Rebate" does not include:
1505 (i) a refund due to termination or changes in coverage;
1506 (ii) a refund due to overcharges made in error by the licensee; or
1507 (iii) savings or wellness benefits as provided in the contract by the licensee.
1508 [~~(159)~~] (162) "Received by the department" means:
1509 (a) the date delivered to and stamped received by the department, if delivered in
1510 person;
1511 (b) the post mark date, if delivered by mail;
1512 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
1513 (d) the received date recorded on an item delivered, if delivered by:

1514 (i) facsimile;
1515 (ii) email; or
1516 (iii) another electronic method; or
1517 (e) a date specified in:
1518 (i) a statute;
1519 (ii) a rule; or
1520 (iii) an order.
1521 [~~(160)~~] (163) "Reciprocal" or "interinsurance exchange" means an unincorporated
1522 association of persons:
1523 (a) operating through an attorney-in-fact common to all of the persons; and
1524 (b) exchanging insurance contracts with one another that provide insurance coverage
1525 on each other.
1526 [~~(161)~~] (164) "Reinsurance" means an insurance transaction where an insurer, for
1527 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1528 reinsurance transactions, this title sometimes refers to:
1529 (a) the insurer transferring the risk as the "ceding insurer"; and
1530 (b) the insurer assuming the risk as the:
1531 (i) "assuming insurer"; or
1532 (ii) "assuming reinsurer."
1533 [~~(162)~~] (165) "Reinsurer" means a person licensed in this state as an insurer with the
1534 authority to assume reinsurance.
1535 [~~(163)~~] (166) "Residential dwelling liability insurance" means insurance against
1536 liability resulting from or incident to the ownership, maintenance, or use of a residential
1537 dwelling that is a detached single family residence or multifamily residence up to four units.
1538 [~~(164)~~] (167) (a) "Retrocession" means reinsurance with another insurer of a liability
1539 assumed under a reinsurance contract.
1540 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a
1541 liability assumed under a reinsurance contract.

1542 [(165)] (168) "Rider" means an endorsement to:
1543 (a) an insurance policy; or
1544 (b) an insurance certificate.
1545 (169) "Scope criteria" means the designated exposure bases and minimum magnitudes
1546 for a specified data year that are used to establish a preliminary list of insurers considered
1547 scoped into the NAIC liquidity stress test framework for that data year.
1548 [(166)] (170) "Secondary medical condition" means a complication related to an
1549 exclusion from coverage in accident and health insurance.
1550 [(167)] (171) (a) "Security" means a:
1551 (i) note;
1552 (ii) stock;
1553 (iii) bond;
1554 (iv) debenture;
1555 (v) evidence of indebtedness;
1556 (vi) certificate of interest or participation in a profit-sharing agreement;
1557 (vii) collateral-trust certificate;
1558 (viii) preorganization certificate or subscription;
1559 (ix) transferable share;
1560 (x) investment contract;
1561 (xi) voting trust certificate;
1562 (xii) certificate of deposit for a security;
1563 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
1564 payments out of production under such a title or lease;
1565 (xiv) commodity contract or commodity option;
1566 (xv) certificate of interest or participation in, temporary or interim certificate for,
1567 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
1568 in Subsections [(167)] (171)(a)(i) through (xiv); or
1569 (xvi) another interest or instrument commonly known as a security.

1570 (b) "Security" does not include:
1571 (i) any of the following under which an insurance company promises to pay money in a
1572 specific lump sum or periodically for life or some other specified period:
1573 (A) insurance;
1574 (B) an endowment policy; or
1575 (C) an annuity contract; or
1576 (ii) a burial certificate or burial contract.
1577 [~~(168)~~] (172) "Securityholder" means a specified person who owns a security of a
1578 person, including:
1579 (a) common stock;
1580 (b) preferred stock;
1581 (c) debt obligations; and
1582 (d) any other security convertible into or evidencing the right of any of the items listed
1583 in this Subsection [~~(168)~~] (172).
1584 [~~(169)~~] (173) (a) "Self-insurance" means an arrangement under which a person
1585 provides for spreading [~~its own~~] the person's own risks by a systematic plan.
1586 (b) "Self-insurance" includes:
1587 (i) an arrangement under which a governmental entity undertakes to indemnify an
1588 employee for liability arising out of the employee's employment; and
1589 (ii) an arrangement under which a person with a managed program of self-insurance
1590 and risk management undertakes to indemnify the person's affiliate, subsidiary, director,
1591 officer, or employee for liability or risk that arises out of the person's relationship with the
1592 affiliate, subsidiary, director, officer, or employee.
1593 [~~(b) Except as provided in this Subsection (169), "self-insurance"~~] (c) "Self-insurance"
1594 does not include:
1595 (i) an arrangement under which a number of persons spread their risks among
1596 themselves[~~.~~]; or
1597 (ii) an arrangement with an independent contractor.

1598 [~~(c) "Self-insurance" includes:~~]

1599 [~~(i) an arrangement by which a governmental entity undertakes to indemnify an~~

1600 ~~employee for liability arising out of the employee's employment; and~~]

1601 [~~(ii) an arrangement by which a person with a managed program of self-insurance and~~

1602 ~~risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or~~

1603 ~~employees for liability or risk that is related to the relationship or employment.~~]

1604 [~~(d) "Self-insurance" does not include an arrangement with an independent contractor.~~]

1605 [~~(170)~~] (174) "Sell" means to exchange a contract of insurance:

1606 (a) by any means;

1607 (b) for money or its equivalent; and

1608 (c) on behalf of an insurance company.

1609 [~~(171)~~] (175) "Short-term limited duration health insurance" means a health benefit

1610 product that:

1611 (a) after taking into account any renewals or extensions, has a total duration of no more

1612 than 36 months; and

1613 (b) has an expiration date specified in the contract that is less than 12 months after the

1614 original effective date of coverage under the health benefit product.

1615 [~~(172)~~] (176) "Significant break in coverage" means a period of 63 consecutive days

1616 during each of which an individual does not have creditable coverage.

1617 [~~(173)~~] (177) (a) "Small employer" means, in connection with a health benefit plan and

1618 with respect to a calendar year and to a plan year, an employer who:

1619 (i) (A) employed at least one but not more than 50 eligible employees on business days

1620 during the preceding calendar year; or

1621 (B) if the employer did not exist for the entirety of the preceding calendar year,

1622 reasonably expects to employ an average of at least one but not more than 50 eligible

1623 employees on business days during the current calendar year;

1624 (ii) employs at least one employee on the first day of the plan year; and

1625 (iii) for an employer who has common ownership with one or more other employers, is

1626 treated as a single employer under 26 U.S.C. Sec. 414(b), (c), (m), or (o).

1627 (b) "Small employer" does not include an owner or a sole proprietor that does not

1628 employ at least one employee.

1629 [(174)] (178) "Special enrollment period," in connection with a health benefit plan, has

1630 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance

1631 Portability and Accountability Act.

1632 [(175)] (179) (a) "Subsidiary" of a person means an affiliate controlled by that person

1633 either directly or indirectly through one or more affiliates or intermediaries.

1634 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting

1635 shares are owned by that person either alone or with its affiliates, except for the minimum

1636 number of shares the law of the subsidiary's domicile requires to be owned by directors or

1637 others.

1638 [(176)] (180) Subject to Subsection [(91)] (92)(b), "surety insurance" includes:

1639 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or

1640 perform the principal's obligations to a creditor or other obligee;

1641 (b) bail bond insurance; and

1642 (c) fidelity insurance.

1643 [(177)] (181) (a) "Surplus" means the excess of assets over the sum of paid-in capital

1644 and liabilities.

1645 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is

1646 designated by the insurer or organization as permanent.

1647 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-205 require

1648 that insurers or organizations doing business in this state maintain specified minimum levels of

1649 permanent surplus.

1650 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the

1651 same as the minimum required capital requirement that applies to stock insurers.

1652 (c) "Excess surplus" means:

1653 (i) for a life insurer, accident and health insurer, health organization, or property and

1654 casualty insurer as defined in Section 31A-17-601, the lesser of:
1655 (A) that amount of an insurer's or health organization's total adjusted capital that
1656 exceeds the product of:
1657 (I) 2.5; and
1658 (II) the sum of the insurer's or health organization's minimum capital or permanent
1659 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
1660 (B) that amount of an insurer's or health organization's total adjusted capital that
1661 exceeds the product of:
1662 (I) 3.0; and
1663 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and
1664 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer
1665 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1666 (A) 1.5; and
1667 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1668 [~~(178)~~] (182) "Third party administrator" or "administrator" means a person who
1669 collects charges or premiums from, or who, for consideration, adjusts or settles claims of
1670 residents of the state in connection with insurance coverage, annuities, or service insurance
1671 coverage, except:
1672 (a) a union on behalf of its members;
1673 (b) a person administering a:
1674 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1675 1974;
1676 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1677 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1678 (c) an employer on behalf of the employer's employees or the employees of one or
1679 more of the subsidiary or affiliated corporations of the employer;
1680 (d) an insurer licensed under the following, but only for a line of insurance for which
1681 the insurer holds a license in this state:

1682 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1683 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;
1684 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
1685 (iv) Chapter 9, Insurance Fraternals; or
1686 (v) Chapter 14, Foreign Insurers;
1687 (e) a person:
1688 (i) licensed or exempt from licensing under:
1689 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1690 Reinsurance Intermediaries; or
1691 (B) Chapter 26, Insurance Adjusters; and
1692 (ii) whose activities are limited to those authorized under the license the person holds
1693 or for which the person is exempt; or
1694 (f) an institution, bank, or financial institution:
1695 (i) that is:
1696 (A) an institution whose deposits and accounts are to any extent insured by a federal
1697 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
1698 Credit Union Administration; or
1699 (B) a bank or other financial institution that is subject to supervision or examination by
1700 a federal or state banking authority; and
1701 (ii) that does not adjust claims without a third party administrator license.
1702 [~~(179)~~] (183) "Title insurance" means the insuring, guaranteeing, or indemnifying of an
1703 owner of real or personal property or the holder of liens or encumbrances on that property, or
1704 others interested in the property against loss or damage suffered by reason of liens or
1705 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
1706 or unenforceability of any liens or encumbrances on the property.
1707 [~~(180)~~] (184) "Total adjusted capital" means the sum of an insurer's or health
1708 organization's statutory capital and surplus as determined in accordance with:
1709 (a) the statutory accounting applicable to the annual financial statements required to be

1710 filed under Section 31A-4-113; and

1711 (b) another item provided by the RBC instructions, as RBC instructions is defined in

1712 Section 31A-17-601.

1713 [(181)] (185) (a) "Trustee" means "director" when referring to the board of directors of

1714 a corporation.

1715 (b) "Trustee," when used in reference to an employee welfare fund, means an

1716 individual, firm, association, organization, joint stock company, or corporation, whether acting

1717 individually or jointly and whether designated by that name or any other, that is charged with

1718 or has the overall management of an employee welfare fund.

1719 [(182)] (186) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted

1720 insurer" means an insurer:

1721 (i) not holding a valid certificate of authority to do an insurance business in this state;

1722 or

1723 (ii) transacting business not authorized by a valid certificate.

1724 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1725 (i) holding a valid certificate of authority to do an insurance business in this state; and

1726 (ii) transacting business as authorized by a valid certificate.

1727 [(183)] (187) "Underwrite" means the authority to accept or reject risk on behalf of the

1728 insurer.

1729 [(184)] (188) "Vehicle liability insurance" means insurance against liability resulting

1730 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a

1731 vehicle comprehensive or vehicle physical damage coverage [under] described in Subsection

1732 [(152)] (155).

1733 [(185)] (189) "Voting security" means a security with voting rights, and includes a

1734 security convertible into a security with a voting right associated with the security.

1735 [(186)] (190) "Waiting period" for a health benefit plan means the period that must

1736 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of

1737 the health benefit plan, can become effective.

1738 [~~(187)~~] (191) "Workers' compensation insurance" means:
1739 (a) insurance for indemnification of an employer against liability for compensation
1740 based on:
1741 (i) a compensable accidental injury; and
1742 (ii) occupational disease disability;
1743 (b) employer's liability insurance incidental to workers' compensation insurance and
1744 written in connection with workers' compensation insurance; and
1745 (c) insurance assuring to a person entitled to workers' compensation benefits the
1746 compensation provided by law.
1747 Section 4. Section **31A-2-210** is amended to read:
1748 **31A-2-210. Participation in organizations.**
1749 (1) The commissioner and the Insurance Department shall maintain close relations with
1750 the commissioners of other states and shall participate in the activities and affairs of the
1751 [~~National Association of Insurance Commissioners~~] NAIC and other organizations to the
1752 extent, in the commissioner's judgment, these activities will promote the purposes of the
1753 Insurance Code. The actual and necessary expenses incurred by this participation shall be paid
1754 out of the Insurance Department appropriation. The commissioner may not make any
1755 commitments that are not terminable on reasonable notice by the commissioner.
1756 (2) The commissioner shall participate in or provide support for participation in a
1757 professional organization that represents states or legislatures for the purpose of preserving
1758 state jurisdiction over the business of insurance.
1759 Section 5. Section **31A-2-403** is amended to read:
1760 **31A-2-403. Title and Escrow Commission created.**
1761 (1) (a) Subject to Subsection (1)(b), there is created within the department the Title and
1762 Escrow Commission that is comprised of five members who shall be, in accordance with Title
1763 63G, Chapter 24, Part 2, Vacancies, appointed by the governor with the advice and consent of
1764 the Senate as follows:
1765 (i) except as provided in Subsection (1)(d), two members shall be employees of a title

1766 insurer;

1767 (ii) two members shall:

1768 (A) be employees of a Utah agency title insurance producer;

1769 (B) be or have been licensed under the title insurance line of authority;

1770 (C) as of the day on which the member is appointed, be or have been licensed with the

1771 title examination or escrow subline of authority for at least five years; and

1772 (D) as of the day on which the member is appointed, not be from the same county as

1773 another member appointed under this Subsection (1)(a)(ii); and

1774 (iii) one member shall be a member of the general public from any county in the state.

1775 (b) No more than one commission member may be appointed from a single company

1776 or an affiliate or subsidiary of the company.

1777 (c) No more than two commission members may be employees of an entity operating

1778 under an affiliated business arrangement, as defined in Section 31A-23a-1001.

1779 (d) If the governor is unable to identify more than one individual who is an employee

1780 of a title insurer and willing to serve as a member of the commission, the commission shall

1781 include the following members in lieu of the members described in Subsection (1)(a)(i):

1782 (i) one member who is an employee of a title insurer; and

1783 (ii) one member who is an employee of a Utah agency title insurance producer.

1784 (2) (a) Subject to Subsection (2)(c), a commission member shall comply with the

1785 conflict of interest provisions described in Title 63G, Chapter 24, Part 3, Conflicts of Interest,

1786 and file with the commissioner a disclosure of any position of employment or ownership

1787 interest that the commission member has with respect to a person that is subject to the

1788 jurisdiction of the commissioner.

1789 (b) The disclosure statement required by this Subsection (2) shall be:

1790 (i) filed by no later than the day on which the person begins that person's appointment;

1791 and

1792 (ii) amended when a significant change occurs in any matter required to be disclosed

1793 under this Subsection (2).

1794 (c) A commission member is not required to disclose an ownership interest that the
1795 commission member has if the ownership interest is in a publicly traded company or held as
1796 part of a mutual fund, trust, or similar investment.
1797 (3) (a) Except as required by Subsection (3)(b), as terms of current commission
1798 members expire, the governor shall appoint each new commission member to a four-year term
1799 ending on June 30.
1800 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the
1801 time of appointment, adjust the length of terms to ensure that the terms of the commission
1802 members are staggered so that approximately half of the members appointed under Subsection
1803 (1)(a)(i) and half of the members appointed under Subsection (1)(a)(ii) are appointed every two
1804 years.
1805 (c) A commission member may not serve more than one consecutive term.
1806 (d) When a vacancy occurs in the membership for any reason, the governor, with the
1807 advice and consent of the Senate, shall appoint a replacement for the unexpired term.
1808 (e) Notwithstanding the other provisions of this Subsection (3), a commission member
1809 serves until a successor is appointed by the governor with the advice and consent of the Senate.
1810 (4) A commission member may not receive compensation or benefits for the
1811 commission member's service, but may receive per diem and travel expenses in accordance
1812 with:
1813 (a) Section 63A-3-106;
1814 (b) Section 63A-3-107; and
1815 (c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and
1816 63A-3-107.
1817 (5) Members of the commission shall annually select one commission member to serve
1818 as chair.
1819 (6) (a) (i) Except as provided in Subsection (6)(b), the commission shall meet at least
1820 monthly.
1821 (ii) (A) The commissioner shall, with the concurrence of the chair of the commission,

1822 designate [at least] one monthly meeting per [quarter] calendar year as an in-person meeting.

1823 [(B) Notwithstanding Section 52-4-207, a commission member shall physically attend
1824 a meeting designated as an in-person meeting under Subsection (6)(a)(ii)(A) and may not
1825 attend through electronic means. A commission member may attend any other commission
1826 meeting, subcommittee meeting, or emergency meeting by electronic means in accordance with
1827 Section 52-4-207.]

1828 (B) A commission member may, after providing advance notice to the commissioner,
1829 attend an in-person meeting through electronic means.

1830 (b) (i) Except as provided in Subsection (6)(b)(ii), the commissioner may, with the
1831 concurrence of the chair of the commission, cancel a monthly meeting of the commission if,
1832 due to the number or nature of pending title insurance matters, the monthly meeting is not
1833 necessary.

1834 (ii) The commissioner may not cancel a monthly meeting designated as an in-person
1835 meeting under Subsection (6)(a)(ii)(A).

1836 (c) The commissioner may call additional meetings:

1837 (i) at the commissioner's discretion;

1838 (ii) upon the request of the chair of the commission; or

1839 (iii) upon the written request of three or more commission members.

1840 (d) (i) Three commission members constitute a quorum for the transaction of business.

1841 (ii) The action of a majority of the commission members when a quorum is present is
1842 the action of the commission.

1843 (7) The commissioner shall staff the commission.

1844 Section 6. Section **31A-4-115** is amended to read:

1845 **31A-4-115. Plan of orderly withdrawal.**

1846 (1) As used in this section, a "line of insurance" means:

1847 (a) a general line of authority;

1848 (b) a general line of insurance;

1849 (c) a limited line insurance;

1850 (d) the small employer group health benefit plan market when there is a discontinuance
1851 of all small employer health benefit plans under Subsection 31A-22-618.6(5)(e);
1852 (e) the large employer group health benefit market when there is a discontinuance of all
1853 large employer health benefit plans under Subsection 31A-22-618.6(5)(e); or
1854 (f) the individual health benefit plan market when there is a discontinuance of all
1855 individual health benefit plans under Subsection 31A-22-618.7(3)(e).
1856 [(1) (a)] (2) When an insurer intends to withdraw from writing a line of insurance in
1857 this state or to reduce its total annual premium volume by 75% or more, the insurer shall file
1858 with the commissioner a plan of orderly withdrawal.
1859 [(b) For purposes of this section, a discontinuance of a health benefit plan is a
1860 withdrawal from a line of insurance under Subsections 31A-22-618.6(5) or 31A-22-618.7(3).]
1861 [(2)] (3) An insurer's plan of orderly withdrawal shall:
1862 (a) indicate the date the insurer intends to:
1863 (i) begin the withdrawal plan; and
1864 (ii) complete [its] the withdrawal plan; and
1865 (b) include provisions for:
1866 (i) meeting the insurer's contractual obligations;
1867 (ii) providing services to [its] the insurer's Utah policyholders and claimants;
1868 (iii) meeting applicable statutory obligations; and
1869 (iv) the payment of a withdrawal fee of $50,000 to the department if the insurer's line
1870 of [business] insurance is not assumed or placed with another insurer approved by the
1871 commissioner.
1872 [(3)] (4) The commissioner shall approve a plan of orderly withdrawal if the plan of
1873 orderly withdrawal adequately demonstrates that the insurer will:
1874 (a) protect the interests of the people of the state;
1875 (b) meet the insurer's contractual obligations;
1876 (c) provide service to the insurer's Utah policyholders and claimants; and
1877 (d) meet applicable statutory obligations.

1878 [(4)] (5) Section 31A-2-302 governs the commissioner's approval or disapproval of a
1879 plan for orderly withdrawal.
1880 [(5)] (6) The commissioner may require an insurer to increase the deposit maintained
1881 in accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in
1882 the name of the commissioner upon finding, after an adjudicative proceeding that:
1883 (a) there is reasonable cause to conclude that the interests of the people of the state are
1884 best served by such action; and
1885 (b) the insurer:
1886 (i) has filed a plan of orderly withdrawal; or
1887 (ii) intends to:
1888 (A) withdraw from writing a line of insurance in this state; or
1889 (B) reduce the insurer's total annual premium volume by 75% or more.
1890 [(6)] (7) An insurer is subject to the civil penalties under Section 31A-2-308, if the
1891 insurer:
1892 (a) withdraws from writing a line of insurance in this state without receiving the
1893 commissioner's approval of a plan of orderly withdrawal; or
1894 (b) reduces [its] the insurer's total annual premium volume by 75% or more in any year
1895 without receiving the commissioner's approval of a plan of orderly withdrawal.
1896 [(7)] (8) An insurer that withdraws from writing [all lines] a line of insurance in this
1897 state may not resume writing the line of insurance in this state for five years unless the
1898 commissioner finds that the prohibition should be waived because the waiver is:
1899 (a) in the public interest to promote competition; or
1900 (b) to resolve inequity in the marketplace.
1901 [(8)] (9) The commissioner shall adopt rules necessary to implement this section.
1902 (10) This section does not apply to an insurer that places coverage with an affiliate of
1903 the insurer with the same or similar coverage.
1904 Section 7. Section **31A-5-506** is amended to read:
1905 **31A-5-506. Conversion of a domestic mutual into a stock corporation.**

1906 (1) (a) Except as provided in Subsection (1)(b), a domestic mutual may be converted
1907 into a domestic stock corporation under Subsections (2) through (11).
1908 (b) A domestic mutual that is affiliated with other mutuals may not be converted into a
1909 stock corporation, unless all the affiliated mutuals are converted at the same time, or the
1910 commissioner finds that the interests of the policyholders of the remaining mutuals can be
1911 permanently protected by limitations on the corporate powers of the new stock corporation or
1912 on its authority to do business, or otherwise.
1913 (2) The board shall pass a resolution stating that the conversion is in the best interests
1914 of the policyholders. The resolution shall specify the reasons for and the purposes of the
1915 proposed conversion, and how the conversion is expected to benefit policyholders.
1916 (3) (a) Chapter 16, Insurance Holding Companies, applies to the conversion of a
1917 domestic mutual into a stock corporation. In addition, the commissioner shall order the
1918 examination and appraisal of the corporation, unless the commissioner finds that:
1919 (i) the resolution is defective upon its face; or
1920 (ii) the basis or the purposes of the proposed conversion are contrary to law, to the
1921 interests of the policyholders, or to the public.
1922 (b) The commissioner shall examine the company and all of its controlled affiliates
1923 under Section 31A-2-203 to determine their financial condition and whether they are operating
1924 in accordance with law.
1925 (c) The commissioner shall appoint an appraisal committee, consisting of at least three
1926 qualified and disinterested persons with differing expertise, to determine the value of the
1927 corporation on the date of the resolution required by Subsection (2). Members of the appraisal
1928 committee shall receive reasonable compensation and shall be reimbursed for reasonable
1929 expenses in discharging their duties. They may employ consultants to advise them on technical
1930 problems of the appraisal, if necessary. The appraisal committee shall consider the assets and
1931 liabilities of the corporation, adjusting liabilities to take account of:
1932 (i) the amounts of any reserves in excess of or below realistic estimates;
1933 (ii) the value of the marketing organization;

1934 (iii) the value of goodwill;
1935 (iv) the going-concern value; and
1936 (v) any other factor having an influence on the value of the corporation.
1937 (4) When the examination and appraisal reports have been made to the commissioner,
1938 the commissioner shall make copies available to the board. The board shall then prepare and
1939 adopt by resolution a plan of conversion. The plan shall be consistent with Subsections (4)(a)
1940 through (e) and shall state how the requirements of those subsections are satisfied.
1941 (a) The plan of conversion shall state the number of shares proposed to be authorized
1942 for the new stock corporation, their par value, if any, and the price per share at which they will
1943 be offered to policyholders. The price per share may not exceed 1/2 of the median equitable
1944 share of all policyholders under Subsection (4)(b).
1945 (b) (i) When an insurer has the type of policies with no investment value to the
1946 policyholders, each person who has been a policyholder and has paid premiums within five
1947 years prior to the resolution under Subsection (2) is entitled, without additional payment, to as
1948 much common stock of the new stock corporation as that person's equitable share of the value
1949 of the converting corporation will purchase. The equitable share is determined by the ratio
1950 which the net premium that person has paid to the corporation during the five years
1951 immediately preceding the resolution required by Subsection (2) bears to the total net
1952 premiums received by the corporation during the same period. The net premium is the gross
1953 premium less the return premium and dividends paid. If the equitable share would only
1954 purchase a fraction of a share of stock, the policyholder has the option of either receiving the
1955 value of the fractional share in cash or purchasing a full share by paying the balance in cash.
1956 (ii) When an insurer has the type of policies with specifically attributable investment
1957 value to the policyholders, each policyholder is entitled, without additional payment, to as
1958 much common stock of the new stock corporation as the policyholder's investment value in the
1959 converting corporation will purchase, determined by the proportion of the policyholder's
1960 investment value to the aggregate investment values of all policyholders. If the policyholder's
1961 share would only purchase a fraction of a share of stock, the policyholder has the option of

1962 either receiving the value of the fractional share in cash or purchasing a full share by paying the
1963 balance in cash.
1964 (c) A written offer shall be sent to each policyholder indicating the policyholder's
1965 individual equitable share and the terms upon which the policyholder may subscribe for stock.
1966 (d) Common shares may not be subscribed by or issued to persons other than
1967 policyholders, until all subscriptions by the policyholders have been filled. After those
1968 subscriptions have been filled, any new issue of stock for five years after the conversion shall
1969 first be offered to the persons who have become shareholders under Subsection (4)(b) in
1970 proportion to their interests under Subsection (4)(b).
1971 (e) A policyholder in a nonlife mutual may not receive a distribution of shares valued
1972 under Subsection (4)(b)(i), which distribution is greater than the amount the policyholder is
1973 entitled to under Section 31A-27a-701. Any excess over the policyholder's entitlement under
1974 Section 31A-27a-701 shall be distributed in accordance with Section 31A-27a-705.
1975 (5) The plan of conversion shall be submitted to the commissioner for approval,
1976 together with:
1977 (a) the proposed articles and bylaws of the new stock corporation which comply with
1978 Section 31A-5-203;
1979 (b) any information specified under Subsection 31A-5-204(2), which the commissioner
1980 reasonably requires; and
1981 (c) a projection of the planned or anticipated financial situation of the new corporation
1982 for five years after the conversion.
1983 (6) The commissioner shall then hold a hearing. The notice of the hearing shall be
1984 mailed to each person who was a policyholder of the corporation on the date of the resolution
1985 required by Subsection (2). This notice shall include a copy of the plan of conversion and any
1986 comments the commissioner considers necessary to adequately inform the policyholders.
1987 (7) The commissioner shall approve the plan of conversion unless the commissioner
1988 finds that the plan violates the law or is contrary to the interests of policyholders or the public.
1989 (8) After approval under Subsection (7), the conversion plan shall be submitted to a

1990 vote of:

1991 (a) for mutuals subject to Subsection (4)(b)(i), those persons who were policyholders
1992 of the mutual on the date of the resolution required by Subsection (2); or

1993 (b) for mutuals subject to Subsection (4)(b)(ii), those persons who had investment
1994 values in their policies as of the date of the resolution required by Subsection (2).

1995 (9) If the policyholders approve the conversion under Subsection (8), the commissioner
1996 shall issue a new certificate of authority. The issuance of the certificate is the conversion of the
1997 mutual to a stock corporation. This stock corporation is considered as being organized at the
1998 time the converted mutual was organized. Subject to the plan of conversion, the directors,
1999 officers, agents, and employees of the mutual shall continue in their same positions with the
2000 stock corporation.

2001 (10) In the proposed conversion, the corporation may not pay any person compensation
2002 other than regular salaries to existing personnel and compensation for clerical and mailing
2003 expenses. With the commissioner's approval, the corporation may pay, at reasonable rates, for
2004 printing costs and for legal and other professional fees for services actually rendered. All
2005 expenses of the conversion, including the expenses incurred by the commissioner and the
2006 prorated salaries of any department staff members involved, shall be paid by the corporation
2007 being converted.

2008 (11) The commissioner's approval of the plan of conversion satisfies the registration
2009 requirement of Section 31A-5-302.

2010 (12) This section does not apply to a mutual reorganization or merger under Section
2011 31A-16-102.6.

2012 Section 8. Section **31A-6a-104** is amended to read:

2013 **31A-6a-104. Required disclosures.**

2014 (1) A reimbursement insurance policy insuring a service contract or a vehicle
2015 protection product warranty that is issued, sold, or offered for sale in this state shall
2016 conspicuously state that, upon failure of the service contract provider or warrantor to perform
2017 under the contract, the issuer of the policy shall:

2018 (a) pay on behalf of the service contract provider or warrantor any sums the service
2019 contract provider or warrantor is legally obligated to pay according to the service contract
2020 provider's or warrantor's contractual obligations under the service contract or a vehicle
2021 protection product warranty issued or sold by the service contract provider or warrantor; or
2022 (b) provide the service which the service contract provider is legally obligated to
2023 perform, according to the service contract provider's contractual obligations under the service
2024 contract issued or sold by the service contract provider.
2025 (2) (a) A service contract may not be issued, sold, or offered for sale in this state unless
2026 the service contract contains the following statements in substantially the following form:
2027 (i) "Obligations of the provider under this service contract are guaranteed under a
2028 service contract reimbursement insurance policy. Should the provider fail to pay or provide
2029 service on any claim within 60 days after proof of loss has been filed, the contract holder is
2030 entitled to make a claim directly against the Insurance Company.";
2031 (ii) "This service contract or warranty is subject to limited regulation by the Utah
2032 Insurance Department. To file a complaint, contact the Utah Insurance Department."; and
2033 (iii) A service contract or reimbursement insurance policy may not be issued, sold, or
2034 offered for sale in this state unless the contract contains a statement in substantially the
2035 following form, "Coverage afforded under this contract is not guaranteed by the Property and
2036 Casualty Guaranty Association."
2037 (b) A vehicle protection product warranty may not be issued, sold, or offered for sale in
2038 this state unless the vehicle protection product warranty contains the following statements in
2039 substantially the following form:
2040 (i) "Obligations of the warrantor under this vehicle protection product warranty are
2041 guaranteed under a reimbursement insurance policy. Should the warrantor fail to pay on any
2042 claim within 60 days after proof of loss has been filed, the warranty holder is entitled to make a
2043 claim directly against the Insurance Company.";
2044 (ii) "This vehicle protection product warranty is subject to limited regulation by the
2045 Utah Insurance Department. To file a complaint, contact the Utah Insurance Department."; and

2046 (iii) as applicable:
2047 (A) "The warrantor under this vehicle protection product warranty will reimburse the
2048 warranty holder as specified in the warranty upon the theft of the vehicle."; or
2049 (B) "The warrantor under this vehicle protection product warranty will reimburse the
2050 warranty holder as specified in the warranty and at the end of the time period specified in the
2051 warranty if, following the theft of the vehicle, the stolen vehicle is not recovered within a time
2052 period specified in the warranty, not to exceed 30 days after the day on which the vehicle is
2053 reported stolen."
2054 (c) A vehicle protection product warranty, or reimbursement insurance policy, may not
2055 be issued, sold, or offered for sale in this state unless the warranty contains a statement in
2056 substantially the following form, "Coverage afforded under this warranty is not guaranteed by
2057 the Property and Casualty Guaranty Association."
2058 (3) (a) A service contract and a vehicle protection product warranty shall:
2059 (i) conspicuously state the name, address, and a toll free claims service telephone
2060 number of the reimbursement insurer;
2061 (ii) (A) identify the service contract provider, the seller, and the service contract holder;
2062 or
2063 (B) identify the warrantor, the seller, and the warranty holder;
2064 (iii) conspicuously state the total purchase price and the terms under which the service
2065 contract or warranty is to be paid;
2066 (iv) conspicuously state the existence of any deductible amount or service fee;
2067 (v) specify the merchandise, service to be provided, and any limitation, exception, or
2068 exclusion;
2069 (vi) state a term, restriction, or condition governing the transferability of the service
2070 contract or warranty; and
2071 (vii) state a term, restriction, or condition that governs cancellation of the service
2072 contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder
2073 or service contract provider.

2074 (b) Beginning January 1, 2021, a service contract shall contain a conspicuous statement
2075 in substantially the following form: "Purchase of this product is optional and is not required in
2076 order to finance, lease, or purchase a motor vehicle."
2077 (4) If prior approval of repair work is required under a home protection service contract
2078 or a vehicle service contract, the contract shall conspicuously state the procedure for obtaining
2079 prior approval and for making a claim, including:
2080 (a) a toll free telephone number for claim service; and
2081 (b) a procedure for obtaining reimbursement for emergency repairs performed outside
2082 of normal business hours.
2083 (5) A preexisting condition clause in a service contract shall specifically state which
2084 preexisting condition is excluded from coverage.
2085 (6) (a) Except as provided in Subsection (6)(c), a service contract shall state the
2086 conditions upon which the use of a nonmanufacturers' part is allowed.
2087 (b) A condition described in Subsection (6)(a) shall comply with applicable state and
2088 federal laws.
2089 (c) This Subsection (6) does not apply to:
2090 (i) a home warranty service contract; or
2091 (ii) a service contract that does not impose an obligation to provide parts.
2092 (7) This section applies to a vehicle protection product warranty, except for the
2093 requirements of Subsections (3)(a)(iv) and (vii), (4), (5), and (6). The department may make
2094 rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to
2095 implement the application of this section to a vehicle protection product warranty.
2096 (8) (a) As used in this Subsection (8), "conspicuous statement" means a disclosure that:
2097 (i) appears in all-caps, bold, and 14-point font; and
2098 (ii) provides a space to be initialed by the consumer:
2099 (A) immediately below the printed disclosure; and
2100 (B) at or before the time the consumer purchases the vehicle protection product.
2101 (b) A vehicle protection product warranty shall contain a conspicuous statement in

2102 substantially the following form: "Purchase of this product is optional and is not required in
2103 order to finance, lease, or purchase a motor vehicle."
2104 (9) If a vehicle protection product warranty states that the warrantor will reimburse the
2105 warranty holder for incidental costs, the vehicle protection product warranty shall state how
2106 incidental costs paid under the warranty are calculated.
2107 (10) If a vehicle protection product warranty states that the warrantor will reimburse
2108 the warranty holder in a fixed amount, the vehicle protection product warranty shall state the
2109 fixed amount.
2110 Section 9. Section **31A-16-102.6** is enacted to read:
2111 **31A-16-102.6. Mutual insurance holding companies.**
2112 (1) As used in this section:
2113 (a) "Intermediate holding company" means a holding company that:
2114 (i) is a subsidiary of a mutual insurance holding company;
2115 (ii) directly or through a subsidiary of the holding company, holds one or more
2116 subsidiary insurers, including a reorganized mutual insurer; and
2117 (iii) if the subsidiary insurers were not held by the holding company, a majority of the
2118 voting shares of the subsidy insurers' capital stock would be required under this section to be
2119 owned by the mutual insurance holding company.
2120 (b) "Majority of the voting shares" means the shares of a reorganized mutual insurer's
2121 capital stock that carry the right to cast a majority of the votes entitled to be cast by all of the
2122 outstanding shares of the reorganized mutual insurer's capital stock for the election of directors
2123 and other matters submitted to a vote of the reorganized mutual insurer's shareholders.
2124 (2) (a) With the commissioner's approval, a domestic mutual insurer may reorganize by
2125 forming a mutual insurance holding company in which:
2126 (i) in accordance with the mutual insurance holding company's articles of incorporation
2127 and bylaws, the membership interests of the domestic mutual insurer's policyholders become
2128 membership interests in the mutual insurance holding company; and
2129 (ii) the domestic mutual insurer is reorganized as a domestic stock insurance company.

2130 (b) The commissioner may approve a domestic mutual insurer's reorganization if:
2131 (i) the domestic mutual insurer's reorganization plan:
2132 (A) properly protects the interests of the domestic mutual insurer's policyholders;
2133 (B) is fair and equitable to the domestic mutual insurer's policyholders; and
2134 (C) satisfies the requirements of Subsections 31A-16-103(8) through (10);
2135 (ii) the initial shares of the reorganized domestic mutual insurer's capital stock are
2136 issued to the mutual insurance holding company or intermediate holding company; and
2137 (iii) at all times, the mutual insurance holding company or intermediate holding
2138 company owns a majority of the voting shares of the reorganized domestic mutual insurer's
2139 capital stock.
2140 (3) (a) With the commissioner's approval, a foreign mutual insurer that would qualify
2141 to become a domestic insurer organized under the laws of this state may reorganize by forming
2142 a mutual insurance holding company system in which:
2143 (i) in accordance with the mutual insurance holding company's articles of incorporation
2144 and bylaws, the membership interests of the foreign mutual insurer's policyholders become
2145 membership interests in the mutual insurance holding company; and
2146 (ii) the foreign mutual insurer is reorganized as a foreign stock insurance company.
2147 (b) The commissioner may approve a foreign mutual insurer's reorganization if:
2148 (i) the foreign mutual insurer's reorganization plan:
2149 (A) complies with any other law or rule applicable to the foreign mutual insurer;
2150 (B) properly protects the interests of the foreign mutual insurer's policyholders;
2151 (C) is fair and equitable to the foreign mutual insurer's policyholders; and
2152 (D) satisfies the requirements of Subsections 31A-16-103(8) through (10);
2153 (ii) the initial shares of the reorganized foreign mutual insurer's capital stock are issued
2154 to the mutual insurance holding company or intermediate holding company; and
2155 (iii) at all times, the mutual insurance holding company or intermediate holding
2156 company owns a majority of the voting shares of the reorganized foreign mutual insurer's
2157 capital stock.

2158 (c) After a merger, the reorganized foreign mutual insurer may:
2159 (i) remain a foreign corporation; and
2160 (ii) with the commissioner's approval, be admitted to conduct business in this state.
2161 (d) A foreign mutual insurer that is a party to a reorganization plan may redomesticate
2162 in this state by complying with the applicable requirements of this state and the foreign mutual
2163 insurer's state of domicile.
2164 (4) (a) As a condition of approval, the commissioner may require a mutual insurer to
2165 modify the mutual insurer's reorganization plan to protect the interests of the mutual insurer's
2166 policyholders.
2167 (b) If the commissioner determines reasonably necessary, at the reorganizing mutual
2168 insurer's expense, the commissioner may retain a third-party consultant to assist the
2169 commissioner in reviewing the mutual insurer's reorganization plan.
2170 (c) The commissioner has jurisdiction over a mutual insurance holding company or
2171 intermediate holding company organized in accordance with this section.
2172 (d) Subject to the commissioner's approval, a reorganized mutual insurer or a stock
2173 insurance subsidiary within a mutual insurance company may issue a dividend or distribution
2174 to the mutual insurance holding company or intermediate holding company.
2175 (5) (a) Subject to the provisions of this section, a mutual insurance holding company
2176 resulting from the reorganization of a domestic mutual insurer shall be incorporated in
2177 accordance with Chapter 5, Domestic Stock and Mutual Insurance Corporations.
2178 (b) A mutual insurance holding company's articles of incorporation and bylaws are
2179 subject to commissioner's approval in the same manner as an insurance company's articles of
2180 incorporation and bylaws.
2181 (6) (a) A mutual insurance holding company is:
2182 (i) subject to Chapter 27a, Insurer Receivership Act; and
2183 (ii) a party to any proceeding under Chapter 27a, Insurer Receivership Act, involving
2184 an insurer that is a subsidiary of the mutual insurance holding company as a result of a
2185 reorganization in accordance with this section.

2186 (b) In a proceeding under Chapter 27a, Insurer Receivership Act, involving a
2187 reorganized mutual insurer, the assets of the mutual insurance holding company are assets of
2188 the estate of the reorganized mutual insurer for the purpose of satisfying the claims of the
2189 reorganized mutual insurer's policyholders.
2190 (c) A mutual insurance holding company may be dissolved or liquidated only by:
2191 (i) prior approval of the commissioner; or
2192 (ii) court order in accordance with Chapter 27a, Insurer Receivership Act.
2193 (7) (a) Section 31A-5-506 does not apply to a mutual insurer's reorganization or merger
2194 under this section.
2195 (b) Section 31A-5-506 applies to demutualization of a mutual insurance holding
2196 company.
2197 (8) A membership interest in a domestic mutual insurance holding company is not a
2198 security under Utah law.
2199 (9) (a) The ownership of a majority of the voting shares of a reorganized mutual
2200 insurer's capital stock includes indirect ownership through one or more intermediate holding
2201 companies in a corporate structure approved by the commissioner.
2202 (b) The indirect ownership described in Subsection (9)(a) may not result in the mutual
2203 insurance holding company owning less than the equivalent of the majority of the voting shares
2204 of the reorganized mutual insurer's capital stock.
2205 (10) (a) A mutual insurance holding company or intermediate holding company may
2206 not sell, transfer, assign, pledge, encumber, hypothecate, alienate, or subject to a security
2207 interest or lien the majority of the voting shares of the reorganized mutual insurer's capital
2208 stock.
2209 (b) An act that violates Subsection (10)(a) is void in reverse chronological order of the
2210 date the act occurred.
2211 (c) The majority of the voting shares of the reorganized mutual insurer's capital stock
2212 are not subject to execution and levy under Utah law.
2213 (d) The shares of the capital stock of the surviving or new company resulting from a

2214 merger or consolidation of two or more reorganized mutual insurers, or two or more
2215 intermediate holding companies that were subsidiaries of the same mutual insurance holding
2216 company, are subject to the same requirements, restrictions, and limitations described in this
2217 section that applied to the shares of the merging or consolidating reorganized mutual insurers
2218 or intermediate holding companies before the merger or consolidation.
2219 (11) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act,
2220 the commissioner may make rules to implement the provisions of this section.
2221 Section 10. Section **31A-16-105** is amended to read:
2222 **31A-16-105. Registration of insurers.**
2223 (1) (a) An insurer that is authorized to do business in this state and that is a member of
2224 an insurance holding company system shall register with the commissioner, except a foreign
2225 insurer subject to registration requirements and standards adopted by statute or regulation in the
2226 jurisdiction of its domicile, if the requirements and standards are substantially similar to those
2227 contained in this section, Subsections 31A-16-106(1)(a) and (2) and either Subsection
2228 31A-16-106(1)(b) or a statutory provision similar to the following: "Each registered insurer
2229 shall keep current the information required to be disclosed in its registration statement by
2230 reporting all material changes or additions within 15 days after the end of the month in which it
2231 learns of each change or addition."
2232 (b) An insurer that is subject to registration under this section shall register within 15
2233 days after it becomes subject to registration, and annually thereafter by June 30 of each year for
2234 the previous calendar year, unless the commissioner for good cause extends the time for
2235 registration and then at the end of the extended time period. The commissioner may require
2236 any insurer authorized to do business in the state, which is a member of a holding company
2237 system, and which is not subject to registration under this section, to furnish a copy of the
2238 registration statement, the summary specified in Subsection (3), or any other information filed
2239 by the insurer with the insurance regulatory authority of domiciliary jurisdiction.
2240 (2) An insurer subject to registration shall file the registration statement with the
2241 commissioner on a form and in a format prescribed by the [~~National Association of Insurance~~

2242 ~~Commissioners~~] NAIC, which shall contain the following current information:

2243 (a) the capital structure, general financial condition, and ownership and management of

2244 the insurer and any person controlling the insurer;

2245 (b) the identity and relationship of every member of the insurance holding company

2246 system;

2247 (c) any of the following agreements in force, and transactions currently outstanding or

2248 which have occurred during the last calendar year between the insurer and its affiliates:

2249 (i) loans, other investments, or purchases, sales or exchanges of securities of the

2250 affiliates by the insurer or of securities of the insurer by its affiliates;

2251 (ii) purchases, sales, or exchanges of assets;

2252 (iii) transactions not in the ordinary course of business;

2253 (iv) guarantees or undertakings for the benefit of an affiliate which result in an actual

2254 contingent exposure of the insurer's assets to liability, other than insurance contracts entered

2255 into in the ordinary course of the insurer's business;

2256 (v) all management agreements, service contracts, and all cost-sharing arrangements;

2257 (vi) reinsurance agreements;

2258 (vii) dividends and other distributions to shareholders; and

2259 (viii) consolidated tax allocation agreements;

2260 (d) any pledge of the insurer's stock, including stock of any subsidiary or controlling

2261 affiliate, for a loan made to any member of the insurance holding company system;

2262 (e) if requested by the commissioner, financial statements of or within an insurance

2263 holding company system, including all affiliates:

2264 (i) which may include annual audited financial statements filed with the United States

2265 Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended, or

2266 the Securities Exchange Act of 1934, as amended; and

2267 (ii) which request is satisfied by providing the commissioner with the most recently

2268 filed parent corporation financial statements that have been filed with the United States

2269 Securities and Exchange Commission;

2270 (f) any other matters concerning transactions between registered insurers and any
2271 affiliates as may be included in any subsequent registration forms adopted or approved by the
2272 commissioner;
2273 (g) statements that the insurer's board of directors oversees corporate governance and
2274 internal controls and that the insurer's officers or senior management have approved,
2275 implemented, and continue to maintain and monitor corporate governance and internal control
2276 procedures; and
2277 (h) any other information required by rule made by the commissioner in accordance
2278 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2279 (3) All registration statements shall contain a summary outlining all items in the
2280 current registration statement representing changes from the prior registration statement.
2281 (4) (a) No information need be disclosed on the registration statement filed pursuant to
2282 Subsection (2) if the information is not material for the purposes of this section.
2283 (b) Unless the commissioner by rule or order provides otherwise, sales, purchases,
2284 exchanges, loans or extensions of credit, investments, or guarantees involving one-half of 1%,
2285 or less, of an insurer's admitted assets as of the next preceding December 31 may not be
2286 considered material for purposes of [~~this section~~] Subsection (2).
2287 (5) Subject to Section 31A-16-106, each registered insurer shall report to the
2288 commissioner a dividend or other distribution to shareholders within 15 business days
2289 following the declaration of the dividend or distribution.
2290 (6) Any person within an insurance holding company system subject to registration
2291 shall provide complete and accurate information to an insurer if the information is reasonably
2292 necessary to enable the insurer to comply with the provisions of this chapter.
2293 (7) The commissioner shall terminate the registration of any insurer which
2294 demonstrates that it no longer is a member of an insurance holding company system.
2295 (8) The commissioner may require or allow two or more affiliated insurers subject to
2296 registration under this section to file a consolidated registration statement.
2297 (9) The commissioner may allow an insurer which is authorized to do business in this

2298 state, and which is part of an insurance holding company system, to register on behalf of any
2299 affiliated insurer which is required to register under Subsection (1) and to file all information
2300 and material required to be filed under this section.
2301 (10) This section does not apply to any insurer, information, or transaction if, and to
2302 the extent that, the commissioner by rule or order exempts the insurer from this section.
2303 (11) Any person may file with the commissioner a disclaimer of affiliation with any
2304 authorized insurer, or a disclaimer of affiliation may be filed by any insurer or any member of
2305 an insurance holding company system. The disclaimer shall fully disclose all material
2306 relationships and bases for affiliation between the person and the insurer as well as the basis for
2307 disclaiming the affiliation. A disclaimer of affiliation is considered to have been granted
2308 unless the commissioner, within 30 days following receipt of a complete disclaimer, notifies
2309 the filing party the disclaimer is disallowed. If disallowed, the disclaiming party may request
2310 an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its
2311 duty to register under this section if approval of the disclaimer is granted by the commissioner,
2312 or if the disclaimer is considered to have been approved.
2313 (12) The ultimate controlling person of an insurer subject to registration shall also file
2314 an annual enterprise risk report. The annual enterprise risk report shall, to the best of the
2315 ultimate controlling person's knowledge and belief, identify the material risks within the
2316 insurance holding company that could pose enterprise risk to the insurer. The annual enterprise
2317 risk report shall be filed with the lead state commissioner of the insurance holding company
2318 system as determined by the procedures within the Financial Analysis Handbook adopted by
2319 the [~~National Association of Insurance Commissioners~~] NAIC.
2320 (13) (a) The ultimate controlling person of an insurer subject to registration shall
2321 concurrently file with the registration an annual group capital calculation report as directed by
2322 the lead state commissioner.
2323 (b) The annual group capital calculation report described in Subsection (13)(a) shall be
2324 filed with the lead state commissioner of the insurance holding company system as determined
2325 by the commissioner in accordance with the procedures within the Financial Analysis

2326 Handbook adopted by the NAIC.

2327 (c) Subject to Subsections (13)(d) and (e), the following insurance holding company
2328 systems are exempt from filing the annual group capital calculation report described in
2329 Subsection (13)(a):

2330 (i) an insurance holding company system that:

2331 (A) has only one insurer within the insurance holding company's structure;

2332 (B) writes business and is licensed only in the insurance holding company system's
2333 domestic state; and

2334 (C) assumes no business from any other insurer;

2335 (ii) an insurance holding company system that is required to perform a group capital
2336 calculation specified by the United States Federal Reserve Board unless:

2337 (A) the lead state commissioner requests the calculation from the Federal Reserve
2338 Board under the terms of information sharing agreements in effect; and

2339 (B) the Federal Reserve Board cannot share the calculation with the lead state
2340 commissioner;

2341 (iii) an insurance holding company system whose non-United States group-wide
2342 supervisor is located within a reciprocal jurisdiction as described in Subsection 31A-17-404(8)
2343 that recognizes the United States' state regulatory approach to group supervision and group
2344 capital; and

2345 (iv) an insurance holding company system:

2346 (A) that provides information to the lead state that meets the requirements for
2347 accreditation under the NAIC financial standards and accreditation program, either directly or
2348 indirectly through the group-wide supervisor, who has determined the information is
2349 satisfactory to allow the lead state to comply with the NAIC group supervision approach, as
2350 detailed in the NAIC Financial Analysis Handbook; and

2351 (B) whose non-United States group-wide supervisor that is not located in a reciprocal
2352 jurisdiction recognizes and accepts, as specified by the lead state commissioner in regulation,
2353 the group capital calculation as the world-wide group capital assessment for United States

2354 insurance groups that operate in that jurisdiction.

2355 (d) If, after consultation with other supervisors or officials, the lead state commissioner

2356 determines appropriate for prudential oversight and solvency monitoring purposes or for

2357 ensuring the competitiveness of the insurance marketplace, the lead state commissioner shall

2358 require the group capital calculation for United States operations of any non-United States

2359 based insurance holding company system.

2360 (e) The lead state commissioner may:

2361 (i) exempt the ultimate controlling person from filing the annual group capital

2362 calculation; or

2363 (ii) accept a limited group capital filing or report in accordance with criteria as

2364 specified by the lead state commissioner in regulation.

2365 (f) If the lead state commissioner determines that an insurance holding company

2366 system no longer meets one or more of the requirements for an exemption from filing the group

2367 capital calculation under this section, the insurance holding company system shall file the

2368 group capital calculation at the next annual filing date unless the lead state commissioner gives

2369 an extension based on reasonable grounds.

2370 (14) (a) The ultimate controlling person of every insurer subject to registration and also

2371 scoped into the NAIC liquidity stress test framework shall file the results of a specific year's

2372 liquidity stress test.

2373 (b) The filing described in Subsection (14)(a) shall be made to the lead state insurance

2374 commissioner of the insurance holding company system as determined by the procedures

2375 within the Financial Analysis Handbook adopted by the NAIC.

2376 (c) Any change to the NAIC liquidity stress test framework or to the data year for

2377 which the scope criteria are to be measured shall be effective on January 1 of the year

2378 following the calendar year in which the change is adopted.

2379 (d) Insurers meeting at least one threshold of the NAIC liquidity stress test framework's

2380 scope criteria are scoped into the NAIC liquidity stress test framework for the specified data

2381 year unless the lead state insurance commissioner, in consultation with the NAIC Financial

2382 Stability Task Force or the NAIC Financial Stability Task Force's successor, determines the
2383 insurer should not be scoped into the NAIC liquidity stress test framework for that data year.
2384 (e) Insurers that do not meet at least one threshold of the NAIC liquidity stress test
2385 framework's scope criteria are scoped out of the NAIC liquidity stress test framework for the
2386 specified data year, unless the lead state insurance commissioner, in consultation with the
2387 NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor,
2388 determines the insurer should be scoped into the NAIC liquidity stress test framework for that
2389 data year.
2390 (f) To avoid having insurers scoped in and out of the NAIC liquidity stress test
2391 framework on a frequent basis, the lead state insurance commissioner, in consultation with the
2392 Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, shall
2393 assess this concern as part of the lead state insurance commissioner's determination of whether
2394 an insurer is scoped into the NAIC liquidity stress test framework for a specified data year.
2395 (g) The performance of, and filing of the results from, a specific year's liquidity stress
2396 test shall comply with:
2397 (i) the NAIC liquidity stress test framework instructions and reporting templates for
2398 that year; and
2399 (ii) lead state insurance commissioner determinations made in conjunction with the
2400 NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor,
2401 provided within the NAIC liquidity stress test framework.
2402 [(13)] (15) The failure to file a registration statement or any summary of the
2403 registration statement or enterprise risk filing required by this section within the time specified
2404 for the filing is a violation of this section.
2405 Section 11. Section **31A-16-106** is amended to read:
2406 **31A-16-106. Standards and management of an insurer within a holding company**
2407 **system.**
2408 (1) (a) Transactions within an insurance holding company system to which an insurer
2409 subject to registration is a party are subject to the following standards:

2410 (i) the terms shall be fair and reasonable;
2411 (ii) agreements for cost sharing services and management shall include the provisions
2412 required by rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah
2413 Administrative Rulemaking Act;
2414 (iii) charges or fees for services performed shall be reasonable;
2415 (iv) expenses incurred and payment received shall be allocated to the insurer in
2416 conformity with customary insurance accounting practices consistently applied;
2417 (v) the books, accounts, and records of each party to all transactions shall be so
2418 maintained as to clearly and accurately disclose the nature and details of the transactions,
2419 including the accounting information necessary to support the reasonableness of the charges or
2420 fees to the respective parties; [~~and~~]
2421 (vi) the insurer's surplus held for policyholders, following any dividends or
2422 distributions to shareholder affiliates, shall be reasonable in relation to the insurer's outstanding
2423 liabilities and shall be adequate to its financial needs[~~.~~];
2424 (vii) the commissioner may require the insurer to secure and maintain a deposit held by
2425 the commissioner or a bond, as determined by the insurer at the insurer's discretion, in an
2426 amount determined by the commissioner not to exceed the value of the agreement in any one
2427 year, if the commissioner:
2428 (A) determines that the insurer is in a hazardous financial condition under Title 31A,
2429 Chapter 27a, Insurer Receivership Act, or a condition that would warrant a delinquency
2430 proceeding under Title 31A, Chapter 27a, Insurer Receivership Act; and
2431 (B) believes that the insurers' affiliate may be unable to fulfill an agreement with the
2432 insurer if the insurer were put into liquidation;
2433 (viii) all insurer records and data held by an affiliate:
2434 (A) are the insurer's property;
2435 (B) are subject to the insurer's control;
2436 (C) are identifiable;
2437 (D) are segregated or readily capable of segregation, at no additional cost to the insurer,

2438 from all other records and data;
2439 (E) shall be provided to a receiver, at the insurer's request, including any information,
2440 software, licensing agreement, release, waiver, or any other thing required to access the records
2441 and data; and
2442 (F) may be restricted in use by the affiliate if the affiliate is not operating the insurer's
2443 business; and
2444 (ix) (A) all funds belonging to the insurer that an affiliate collects or holds are the
2445 exclusive property of the insurer and subject to the control of the insurer; and
2446 (B) if the insurer is placed into receivership, any right of offset against the funds is
2447 subject to Title 31A, Chapter 27a, Insurance Receivership Act.
2448 (b) The following transactions involving a domestic insurer and any person in its
2449 insurance holding company system, including amendments or modifications of affiliate
2450 agreements previously filed pursuant to this section, which are subject to any materiality
2451 standards contained in Subsections (1)(a)(i) through (vi), may not be entered into unless the
2452 insurer has notified the commissioner in writing of its intention to enter into the transaction at
2453 least 30 days before entering into the transaction, or within any shorter period the
2454 commissioner may permit, if the commissioner has not disapproved the transaction within the
2455 period. The notice for an amendment or modification shall include the reasons for the change
2456 and financial impact on the domestic insurer. Informal notice shall be reported, within 30 days
2457 after a termination of a previously filed agreement, to the commissioner for determination of
2458 the type of filing required, if any:
2459 (i) sales, purchases, exchanges, loans or extensions of credit, guarantees, or
2460 investments if the transactions are equal to, or exceed as of the next preceding December 31:
2461 (A) for nonlife insurers, the lesser of 3% of the insurer's admitted assets or 25% of
2462 surplus held for policyholders;
2463 (B) for life insurers, 3% of the insurer's admitted assets;
2464 (ii) loans or extensions of credit made to any person who is not an affiliate, if the
2465 insurer makes the loans or extensions of credit with the agreement or understanding that the

2466 proceeds of the transactions, in whole or in substantial part, are to be used to make loans or
2467 extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the
2468 insurer making the loans or extensions of credit if the transactions are equal to, or exceed as of
2469 the next preceding December 31:
2470 (A) for nonlife insurers, the lesser of 3% of the insurer's admitted assets or 25% of
2471 surplus held for policyholders;
2472 (B) for life insurers, 3% of the insurer's admitted assets;
2473 (iii) reinsurance agreements or modifications to reinsurance agreements, including an
2474 agreement in which the reinsurance premium, a change in the insurer's liabilities, or the
2475 projected reinsurance premium or a change in the insurer's liabilities in any of the current and
2476 succeeding three years, equals or exceeds 5% of the insurer's surplus held for policyholders, as
2477 of the next preceding December 31, including those agreements that may require as
2478 consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or
2479 understanding exists between the insurer and the non-affiliate that any portion of the assets will
2480 be transferred to one or more affiliates of the reinsurer;
2481 (iv) all management agreements, service contracts, tax allocation agreements, and all
2482 cost-sharing arrangements;
2483 (v) guarantees when made by a domestic insurer, except that:
2484 (A) a guarantee that is quantifiable as to amount is not subject to the notice
2485 requirements of this Subsection (1) unless it exceeds the lesser of .5% of the insurer's admitted
2486 assets or 10% of surplus held for policyholders, as of the next preceding December 31; and
2487 (B) a guarantee that is not quantifiable as to amount is subject to the notice
2488 requirements of this Subsection (1);
2489 (vi) direct or indirect acquisitions or investments in a person that controls the insurer or
2490 in an affiliate of the insurer in an amount that, together with its present holdings in the
2491 investments, exceeds 2.5% of the insurer's surplus to policyholders, except that a direct or
2492 indirect acquisition or investment in a subsidiary acquired pursuant to Section 31A-16-102.5,
2493 or in a non-subsidiary insurance affiliate that is subject to this chapter, is exempt from this

2494 Subsection (1)(b)(vi);

2495 (vii) any material transactions, specified by rule, which the commissioner determines
2496 may adversely affect the interests of the insurer's policyholders; and

2497 (viii) this Subsection (1) may not be interpreted to authorize or permit any transactions
2498 which would be otherwise contrary to law in the case of an insurer not a member of the same
2499 holding company system.

2500 (c) A domestic insurer may not enter into transactions which are part of a plan or series
2501 of like transactions with persons within the holding company system if the purpose of the
2502 separate transactions is to avoid the statutory threshold amount and thus to avoid the review by
2503 the commissioner that would occur otherwise. If the commissioner determines that the
2504 separate transactions were entered into over any 12 month period for such a purpose, the
2505 commissioner may exercise the commissioner's authority under Section 31A-16-110.

2506 (d) The commissioner, in reviewing transactions pursuant to Subsection (1)(b), shall
2507 consider whether the transactions comply with the standards set forth in Subsection (1)(a) and
2508 whether they may adversely affect the interests of policyholders.

2509 (e) The commissioner shall be notified within 30 days of any investment of the
2510 domestic insurer in any one corporation, if the total investment in the corporation by the
2511 insurance holding company system exceeds 10% of the corporation's voting securities.

2512 (2) (a) A domestic insurer may not pay any extraordinary dividend or make any other
2513 extraordinary distribution to its shareholders until:

2514 (i) 30 days after the commissioner has received notice of the declaration of the
2515 dividend and has not within the 30-day period disapproved the payment; or

2516 (ii) the commissioner has approved the payment within the 30-day period.

2517 (b) For purposes of this Subsection (2), an extraordinary dividend or distribution
2518 includes any dividend or distribution of cash or other property, fair market value of which,
2519 together with that of other dividends or distributions made within the preceding 12 months,
2520 exceeds the lesser of:

2521 (i) 10% of the insurer's surplus held for policyholders as of the next preceding

2522 December 31;

2523 (ii) the net gain from operations of the insurer, if the insurer is a life insurer, or the net

2524 income, if the insurer is not a life insurer, not including realized capital gains, for the 12-month

2525 period ending the next preceding December 31; or

2526 (iii) an extraordinary dividend does not include pro rata distributions of any class of the

2527 insurer's own securities.

2528 (c) In determining whether a dividend or distribution is extraordinary, an insurer other

2529 than a life insurer may carry forward net income from the previous two calendar years that has

2530 not already been paid out as dividends. This carry-forward shall be computed by taking the net

2531 income from the second and third preceding calendar years, not including realized capital

2532 gains, less dividends paid in the second and immediate preceding calendar years.

2533 (d) Notwithstanding any other provision of law, an insurer may declare an

2534 extraordinary dividend or distribution, which is conditioned upon the commissioner's approval

2535 of the dividend or distribution, and the declaration shall confer no rights upon shareholders

2536 until:

2537 (i) the commissioner has approved the payment of the dividend or distribution; or

2538 (ii) the commissioner has not disapproved the payment within the 30-day period

2539 referred to in Subsection (2)(a).

2540 (3) (a) Notwithstanding the control of a domestic insurer by any person, the officers

2541 and directors of the insurer may not be relieved of any obligation or liability to which they

2542 would otherwise be subject by law, and the insurer shall be managed so as to assure its separate

2543 operating identity consistent with this chapter.

2544 (b) Nothing in this section precludes a domestic insurer from having or sharing a

2545 common management or cooperative or joint use of personnel, property, or services with one or

2546 more other persons under arrangements meeting the standards of Subsection (1)(a).

2547 (c) (i) Not less than one-third of the directors of a domestic insurer, and not less than

2548 one-third of the members of each committee of the board of directors of a domestic insurer,

2549 shall be persons who are not officers or employees of the insurer or of any entity controlling,

2550 controlled by, or under common control with the insurer and who are not beneficial owners of a
2551 controlling interest in the voting stock of the insurer or entity.
2552 (ii) At least one person described in Subsection (3)(c)(i) shall be included in a quorum
2553 for the transaction of business at a meeting of the board of directors or a committee of the
2554 board of directors.
2555 (d) Subsection (3)(c) does not apply to a domestic insurer if the person controlling the
2556 insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation,
2557 has a board of directors and committees of the board of directors that meet the requirements of
2558 Subsection (3)(c) with respect to the controlling entity.
2559 (e) An insurer may make application to the commissioner for a waiver from the
2560 requirements of this Subsection (3) if the insurer's annual direct written and assumed premium,
2561 excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood
2562 Program, is less than $300,000,000. An insurer may also make application to the
2563 commissioner for a waiver from the requirements of this Subsection (3) based upon unique
2564 circumstances. The commissioner may consider various factors, including:
2565 (i) the type of business entity;
2566 (ii) the volume of business written;
2567 (iii) the availability of qualified board members; or
2568 (iv) the ownership or organizational structure of the entity.
2569 (4) (a) For purposes of this chapter, in determining whether an insurer's surplus as
2570 regards policyholders is reasonable in relation to the insurer's outstanding liabilities and
2571 adequate to meet its financial needs, the following factors, among others, shall be considered:
2572 (i) the size of the insurer as measured by its assets, capital and surplus, reserves,
2573 premium writings, insurance in force, and other appropriate criteria;
2574 (ii) the extent to which the insurer's business is diversified among several lines of
2575 insurance;
2576 (iii) the number and size of risks insured in each line of business;
2577 (iv) the extent of the geographical dispersion of the insurer's insured risks;

2578 (v) the nature and extent of the insurer's reinsurance program;
2579 (vi) the quality, diversification, and liquidity of the insurer's investment portfolio;
2580 (vii) the recent past and projected future trend in the size of the insurer's investment
2581 portfolio;
2582 (viii) the surplus as regards policyholders maintained by other comparable insurers;
2583 (ix) the adequacy of the insurer's reserves; and
2584 (x) the quality and liquidity of investments in affiliates.
2585 (b) The commissioner may treat an investment described in Subsection (4)(a)(x) as a
2586 disallowed asset for purposes of determining the adequacy of surplus as regards policyholders
2587 whenever in the judgment of the commissioner the investment so warrants.
2588 Section 12. Section **31A-16-109** is amended to read:
2589 **31A-16-109. Confidentiality of information obtained by commissioner.**
2590 (1) (a) Documents, materials, or information obtained by or disclosed to the
2591 commissioner or any other person in the course of an examination or investigation made under
2592 Section 31A-16-107.5, and all information reported or provided to the department under
2593 Section 31A-16-105 or 31A-16-108.6, is proprietary, contains trade secrets, and is confidential.
2594 (b) Any confidential document, material, or information described in Subsection (1)(a)
2595 is not subject to subpoena and may not be made public by the commissioner or any other
2596 person without the permission of the insurer, except the confidential document, material, or
2597 information may be provided to the insurance departments of other states, without the prior
2598 written consent of the insurer to which the confidential document, material, or information
2599 pertains.
2600 (c) The commissioner shall maintain the confidentiality of the following received in
2601 accordance with Section 31A-16-105 from an insurance holding company supervised by the
2602 Federal Reserve Board or any United States group-wide supervisor:
2603 (i) a group capital calculation;
2604 (ii) a group capital ratio produced within the group capital calculation; or
2605 (iii) group capital information.

2606 (d) The commissioner shall maintain the confidentiality of the liquidity stress test
2607 results, supporting disclosures, and any liquidity stress test information received in accordance
2608 with Section 31A-16-105 from an insurance holding company supervised by the Federal
2609 Reserve Board and non-United States group-wide supervisors.
2610 (2) The commissioner and any person who receives documents, materials, or other
2611 information while acting under the authority of the commissioner or with whom the
2612 documents, materials, or other information are shared pursuant to this chapter shall keep
2613 confidential any confidential documents, materials, or information subject to Subsection (1).
2614 (3) [(a)] To assist in the performance of the commissioner's duties, the commissioner:
2615 [(i)] (a) may share documents, materials, proprietary and trade secret documents, or
2616 other information, including the confidential documents, materials, or information subject to
2617 Subsection (1), with the following if the recipient agrees in writing to maintain the
2618 confidentiality status of the document, material, or other information, and has verified in
2619 writing the legal authority to maintain confidentiality:
2620 [(A)] (i) a state, federal, or international regulatory agency;
2621 [(B)] (ii) the [National Association of Insurance Commissioners or an NAIC affiliate or
2622 subsidiary; or] NAIC;
2623 (iii) a third-party consultant designated by the commissioner; or
2624 [(C)] (iv) a state, federal, or international law enforcement authority, including a
2625 member of a supervisory college described in Section 31A-16-108.5;
2626 [(ii)] (b) notwithstanding Subsection (1), may only share confidential documents,
2627 material, or information reported pursuant to Section 31A-16-105 or 31A-16-108.6 with a
2628 commissioner of a state having statutes or regulations substantially similar to Subsection (1)
2629 and who has agreed in writing not to disclose the documents, material, or information;
2630 [(iii)] (c) may receive documents, materials, proprietary and trade secret information,
2631 or other information, including otherwise confidential documents, materials, or information
2632 from:
2633 [(A)] (i) the [National Association of Insurance Commissioners] NAIC or an NAIC

2634 affiliate or subsidiary; or

2635 [~~(B)~~] (ii) a regulatory or law enforcement official of a foreign or domestic jurisdiction;

2636 [~~(iv)~~] (d) shall maintain as confidential any document, material, or information

2637 received under this section with notice or the understanding that it is confidential under the

2638 laws of the jurisdiction that is the source of the document, material, or information; and

2639 [~~(v)~~] (e) shall enter into written agreements with the [~~National Association of Insurance~~

2640 ~~Commissioners~~] NAIC or a third-party consultant designated by the commissioner governing

2641 sharing and use of information provided pursuant to this chapter consistent with this

2642 Subsection (3) that shall:

2643 [~~(A)~~] (i) specify procedures and protocols regarding the confidentiality and security of

2644 information shared with the [~~National Association of Insurance Commissioners~~] NAIC and

2645 NAIC affiliates and subsidiaries pursuant to this chapter, including procedures and protocols

2646 for sharing by the [~~National Association of Insurance Commissioners~~] NAIC with other state,

2647 federal, or international regulators;

2648 [~~(B)~~] (ii) specify that ownership of information shared with the [~~National Association~~

2649 ~~of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries pursuant to this

2650 chapter remains with the commissioner and the [~~National Association of Insurance~~

2651 ~~Commissioner's~~] NAIC's use of the information is subject to the direction of the commissioner;

2652 [~~(C)~~] (iii) require prompt notice to be given to an insurer whose confidential

2653 information in the possession of the [~~National Association of Insurance Commissioners~~] NAIC

2654 pursuant to this chapter is subject to a request or subpoena to the [~~National Association of~~

2655 ~~Insurance Commissioners~~] NAIC for disclosure or production; and

2656 [~~(D)~~] (iv) require the [~~National Association of Insurance Commissioners~~] NAIC and

2657 NAIC affiliates and subsidiaries to consent to intervention by an insurer in any judicial or

2658 administrative action in which the [~~National Association of Insurance Commissioners~~] NAIC

2659 and NAIC affiliates and subsidiaries may be required to disclose confidential information about

2660 the insurer shared with the [~~National Association of Insurance Commissioners~~] NAIC and

2661 NAIC affiliates and subsidiaries pursuant to this chapter.

2662 (4) The sharing of information by the commissioner pursuant to this chapter does not
2663 constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely
2664 responsible for the administration, execution, and enforcement of this chapter.
2665 (5) A waiver of any applicable claim of confidentiality in the documents, materials, or
2666 information does not occur as a result of disclosure to the commissioner under this section or
2667 as a result of sharing as authorized in Subsection (3).
2668 (6) Documents, materials, or other information in the possession or control of the
2669 [~~National Association of Insurance Commissioners~~] NAIC pursuant to this chapter are:
2670 (a) confidential, not public records, and not open to public inspection; and
2671 (b) not subject to Title 63G, Chapter 2, Government Records Access and Management
2672 Act.
2673 (7) (a) The group capital calculation, including the resulting group capital ratio, and the
2674 liquidity stress test, including the liquidity stress test results and supporting disclosures, are:
2675 (i) regulatory tools for assessing risk and capital adequacy; and
2676 (ii) not a method to rank insurers or insurance holding company systems generally.
2677 (b) Except as provided in Subsection (7)(c), an insurer, broker, or other person engaged
2678 in the business of insurance may not make, disseminate, or circulate to the public a materially
2679 false or misleading statement relating to an insurer's or insurer group's, or a component of an
2680 insurer's or insurer group's:
2681 (i) group capital calculation;
2682 (ii) group capital ratio;
2683 (iii) liquidity stress test results; or
2684 (iv) liquidity stress test supporting disclosures.
2685 (c) If an insurer provides to the commissioner substantial proof that a statement
2686 described in Subsection (7)(b) is materially false or misleading, the insurer may publish an
2687 announcement in a written publication for the sole purpose of rebutting the materially false or
2688 misleading statement.
2689 Section 13. Section **31A-17-408** is amended to read:

2690 **31A-17-408. Title insurance reserves.**

2691 (1) In addition to an adequate reserve for outstanding losses, a title insurance company
2692 shall either:

2693 (a) maintain and segregate an unearned premium reserve fund of not less than 10 cents
2694 for each $1,000 face amount of retained liability under each title insurance contract or policy
2695 on a single insurance risk issued; or

2696 (b) have the commissioner review and approve a contract of reinsurance applicable to
2697 the title insurance company's policies, which contract adequately covers the exposure or risk
2698 which the unearned premium reserve would serve.

2699 (2) The fund shall be maintained for the protection of policyholders and is not subject
2700 to the claims of stockholders or creditors other than policyholders.

2701 (3) The title insurance company may release the fund in accordance with the standards
2702 of the NAIC Accounting Practices and Procedures Manual.

2703 Section 14. Section **31A-17-601** is amended to read:

2704 **31A-17-601. Definitions.**

2705 As used in this part:

2706 (1) "Adjusted RBC report" means an RBC report that has been adjusted by the
2707 commissioner in accordance with Subsection 31A-17-602(5).

2708 (2) "Corrective order" means an order issued by the commissioner specifying
2709 corrective action that the commissioner determines is required.

2710 (3) "Health organization" means:

2711 (a) an entity that is authorized under Chapter 7, Nonprofit Health Service Insurance
2712 Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

2713 (b) that is:

2714 (i) a health maintenance organization;

2715 (ii) a limited health service organization;

2716 (iii) a dental or vision plan;

2717 (iv) a hospital, medical, and dental indemnity or service corporation; or

2718 (v) other managed care organization.
2719 (4) "Life or accident and health insurer" means:
2720 (a) an insurance company licensed to write life insurance, [~~disability~~] accident and
2721 health insurance, or both; or
2722 (b) a licensed property casualty insurer writing only disability insurance.
2723 (5) "Property and casualty insurer" means any insurance company licensed to write
2724 lines of insurance other than life but does not include a monoline mortgage guaranty insurer,
2725 financial guaranty insurer, or title insurer.
2726 (6) "RBC" means risk-based capital.
2727 (7) "RBC instructions" means the RBC report including the National Association of
2728 Insurance Commissioner's risk-based capital instructions that govern the year for which an
2729 RBC report is prepared.
2730 (8) "RBC level" means an insurer's or health organization's authorized control level
2731 RBC, company action level RBC, mandatory control level RBC, or regulatory action level
2732 RBC.
2733 (a) "Authorized control level RBC" means the number determined under the risk-based
2734 capital formula in accordance with the RBC instructions;
2735 (b) "Company action level RBC" means the product of 2.0 and its authorized control
2736 level RBC;
2737 (c) "Mandatory control level RBC" means the product of .70 and the authorized control
2738 level RBC; and
2739 (d) "Regulatory action level RBC" means the product of 1.5 and its authorized control
2740 level RBC.
2741 (9) (a) "RBC plan" means a comprehensive financial plan containing the elements
2742 specified in Subsection 31A-17-603(2).
2743 (b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:
2744 (i) the commissioner rejects the RBC plan; and
2745 (ii) the plan is revised by the insurer or health organization, with or without the

2746 commissioner's recommendation.

2747 (10) "RBC report" means the report required in Section 31A-17-602.

2748 Section 15. Section **31A-21-201** is amended to read:

2749 **31A-21-201. Filing of forms.**

2750 (1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may

2751 not be used, sold, or offered for sale until the form is filed with the commissioner.

2752 (b) A form is considered filed with the commissioner when the commissioner receives:

2753 (i) the form;

2754 (ii) the applicable filing fee as prescribed under Section 31A-3-103; and

2755 (iii) the applicable transmittal forms as required by the commissioner.

2756 (2) In filing a form for use in this state the insurer is responsible for assuring that the

2757 form is in compliance with this title and rules adopted by the commissioner.

2758 (3) (a) The commissioner may prohibit the use of a form at any time upon a finding

2759 that:

2760 (i) the form:

2761 (A) is inequitable;

2762 (B) is unfairly discriminatory;

2763 (C) is misleading;

2764 (D) is deceptive;

2765 (E) is obscure;

2766 (F) is unfair;

2767 (G) encourages misrepresentation; or

2768 (H) is not in the public interest;

2769 (ii) the form provides benefits or contains another provision that endangers the solidity

2770 of the insurer;

2771 (iii) except for a life or accident and health insurance policy form, the form is an

2772 insurance policy or application for an insurance policy, that fails to conspicuously provide:

2773 (A) the exact name of the insurer; and

2774 (B) the state of domicile of the insurer filing the insurance policy or application for the
2775 insurance policy;
2776 (iv) except an application required by Section 31A-22-635, the form is a life or
2777 accident and health insurance [~~policy~~] form that fails to conspicuously provide:
2778 (A) the exact name of the insurer;
2779 (B) the state of domicile of the insurer [~~filing the insurance policy or application for the~~
2780 ~~insurance policy~~]; and
2781 (C) for a life insurance policy only, the address of the administrative office of the
2782 insurer filing the form;
2783 (v) the form violates a statute or a rule adopted by the commissioner; or
2784 (vi) the form is otherwise contrary to law.
2785 (b) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the
2786 commissioner may order that, on or before a date not less than 15 days after the day on which
2787 the commissioner issues the order, the use of the form be discontinued.
2788 (ii) Once use of a form is prohibited, the form may not be used until appropriate
2789 changes are filed with and reviewed by the commissioner.
2790 (iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the
2791 commissioner may require the insurer to disclose contract deficiencies to the existing
2792 policyholders.
2793 (c) If the commissioner prohibits use of a form under this Subsection (3), the
2794 prohibition shall:
2795 (i) be in writing;
2796 (ii) constitute an order; and
2797 (iii) state the reasons for the prohibition.
2798 (4) (a) If, after a hearing, the commissioner determines that it is in the public interest,
2799 the commissioner may require by rule or order that a form be subject to the commissioner's
2800 approval before an insurer uses the form.
2801 (b) The rule or order described in Subsection (4)(a) shall prescribe the filing

2802 procedures for a form if the procedures are different from the procedures stated in this section.

2803 (c) The type of form that under Subsection (4)(a) the commissioner may require

2804 approval of before use includes:

2805 (i) a form for a particular class of insurance;

2806 (ii) a form for a specific line of insurance;

2807 (iii) a specific type of form; or

2808 (iv) a form for a specific market segment.

2809 (5) (a) An insurer shall maintain a complete and accurate record of the following for

2810 the time period described in Subsection (5)(b):

2811 (i) a form:

2812 (A) filed under this section for use; or

2813 (B) that is in use; and

2814 (ii) a document filed under this section with a form described in Subsection (5)(a)(i).

2815 (b) The insurer shall maintain a record required under Subsection (5)(a) for the balance

2816 of the current year, plus five years from:

2817 (i) the last day on which the form is used; or

2818 (ii) the last day an insurance policy that is issued using the form is in effect.

2819 Section 16. Section **31A-21-303** is amended to read:

2820 **31A-21-303. Cancellation, issuance, and renewal.**

2821 (1) (a) Except as otherwise provided in this section, other statutes, or by rule under

2822 Subsection (1)(c), this section applies to all policies of insurance:

2823 (i) except for:

2824 (A) life insurance;

2825 (B) accident and health insurance; and

2826 (C) annuities; and

2827 (ii) if the policies of insurance are issued on forms that are subject to filing under

2828 Subsection 31A-21-201(1).

2829 (b) A policy may provide terms more favorable to insureds than this section requires.

2830 (c) The commissioner may by rule totally or partially exempt from this section classes
2831 of insurance policies in which the insureds do not need protection against arbitrary or
2832 unannounced termination.
2833 (d) The rights provided by this section are in addition to and do not prejudice any other
2834 rights the insureds may have at common law or under other statutes.
2835 (2) (a) As used in this Subsection (2), "grounds" means:
2836 (i) material misrepresentation;
2837 (ii) substantial change in the risk assumed, unless the insurer should reasonably have
2838 foreseen the change or contemplated the risk when entering into the contract;
2839 (iii) substantial breaches of contractual duties, conditions, or warranties;
2840 (iv) attainment of the age specified as the terminal age for coverage, in which case the
2841 insurer may cancel by notice under Subsection (2)(c), accompanied by a tender of proportional
2842 return of premium; or
2843 (v) in the case of motor vehicle insurance, revocation or suspension of the driver's
2844 license of:
2845 (A) the named insured; or
2846 (B) any other person who customarily drives the motor vehicle.
2847 (b) (i) Except as provided in Subsection (2)(e) or unless the conditions of Subsection
2848 (2)(b)(ii) are met, an insurance policy may not be canceled by the insurer before the earlier of:
2849 (A) the expiration of the agreed term; or
2850 (B) one year from the effective date of the policy or renewal.
2851 (ii) Notwithstanding Subsection (2)(b)(i), an insurance policy may be canceled by the
2852 insurer for:
2853 (A) nonpayment of a premium when due; or
2854 (B) on grounds defined in Subsection (2)(a).
2855 (c) (i) The cancellation provided by Subsection (2)(b), except cancellation for
2856 nonpayment of premium, is effective no sooner than 30 days after the delivery or first-class
2857 mailing of a written notice to the policyholder.

2858 (ii) Cancellation for nonpayment of premium of a personal lines policy is effective no
2859 sooner than 10 days after delivery or first-class mailing of a written notice to the policyholder.
2860 (iii) Cancellation for nonpayment of premium of a commercial lines policy is effective
2861 no sooner than 10 days after delivery or first-class mailing of a written notice to:
2862 (A) the policyholder;
2863 (B) each assignee of the policyholder, if the assignee is named in the policy; and
2864 (C) each loss payee or mortgagee or lienholder under property insurance of the
2865 policyholder, if the loss payee, mortgagee, or lienholder is named in the policy.
2866 (iv) An insurer shall deliver or send by first-class mail a copy of the notice of
2867 cancellation for nonpayment of premium described in Subsection (2)(c)(iii) to an agent of
2868 record of the policyholder on or before the day on which the insurer provides the notice to the
2869 policyholder.
2870 (d) (i) Notice of cancellation for nonpayment of premium shall include a statement of
2871 the reason for cancellation.
2872 (ii) Subsection (7) applies to the notice required for grounds of cancellation other than
2873 nonpayment of premium.
2874 (e) (i) Subsections (2)(a) through (d) do not apply to any insurance contract that has not
2875 been previously renewed if the contract has been in effect less than 60 days on the day on
2876 which the written notice of cancellation is mailed or delivered.
2877 (ii) A cancellation under this Subsection (2)(e) may not be effective until at least 10
2878 days after the day on which a written notice of cancellation is delivered to the insured.
2879 (iii) If the notice required by this Subsection (2)(e) is sent by first-class mail, postage
2880 prepaid, to the insured at the insured's last-known address, delivery is considered accomplished
2881 after the passing, since the mailing date, of the mailing time specified in the Utah Rules of
2882 Civil Procedure.
2883 (iv) A policy cancellation subject to this Subsection (2)(e) is not subject to the
2884 procedures described in Subsection (7).
2885 (3) A policy may be issued for a term longer than one year or for an indefinite term if

2886 the policy includes a clause providing for cancellation by the insurer by giving notice as
2887 provided in Subsection (4)(b)(i) 30 days before an anniversary date.
2888 (4) (a) Subject to Subsections (2), (3), and (4)(b), a policyholder has a right to have the
2889 policy renewed:
2890 (i) on the terms then being applied by the insurer to similar risks; and
2891 (ii) (A) for an additional period of time equivalent to the expiring term if the agreed
2892 term is one year or less; or
2893 (B) for one year if the agreed term is longer than one year.
2894 (b) Except as provided in Subsections (4)(c) and (5), the right to renewal under
2895 Subsection (4)(a) is extinguished if:
2896 (i) at least 30 days before the day on which the policy expires or completes an
2897 anniversary, the insurer delivers or sends by first-class mail a notice of intention not to renew
2898 the policy beyond the agreed expiration or anniversary date to the policyholder at the
2899 policyholder's last-known address;
2900 (ii) not more than 45 nor less than 14 days before the day on which the renewal
2901 premium is due, the insurer delivers or sends by first-class mail a notice to the policyholder at
2902 the policyholder's last-known address, clearly stating:
2903 (A) the renewal premium;
2904 (B) how the renewal premium may be paid, including the due date for payment of the
2905 renewal premium;
2906 (C) that failure to pay the renewal premium extinguishes the policyholder's right to
2907 renewal; and
2908 (D) subject to Subsection (4)(e), that the extinguishment of the right to renew for
2909 nonpayment of premium is effective no sooner than at least 10 days after delivery or first-class
2910 mailing of a written notice to the policyholder that the policyholder has failed to pay the
2911 premium when due;
2912 (iii) the policyholder has:
2913 (A) accepted replacement coverage; or

2914 (B) requested or agreed to nonrenewal; or

2915 (iv) the policy is expressly designated as nonrenewable.

2916 (c) Unless the conditions of Subsection (4)(b)(iii) or (iv) apply, an insurer may not fail
2917 to renew an insurance policy as a result of a telephone call or other inquiry that:

2918 (i) references a policy coverage; and

2919 (ii) does not result in the insured requesting payment of a claim.

2920 (d) Failure to renew under this Subsection (4) is subject to Subsection (5).

2921 (e) (i) (A) If the policy is a personal lines policy, during the period that begins when an
2922 insurer delivers or sends by first-class mail the notice described in Subsection (4)(b)(ii)(D) and
2923 ends when the premium is paid, coverage exists and premiums are due.

2924 (B) If the policy is a commercial lines policy, during the period that begins when an
2925 insurer delivers or sends by first-class mail the notice described in Subsection (2)(c)(iii) and
2926 ends when the premium is paid, coverage exists and premiums are due.

2927 (ii) (A) If after receiving the notice required by Subsection (4)(b)(ii)(D) a personal
2928 lines policyholder fails to pay the renewal premium, the coverage is extinguished as of the date
2929 the renewal premium is originally due.

2930 (B) If after receiving the notice required under Subsection (2)(c)(iii), a commercial
2931 lines policyholder fails to pay the renewal premium within the 10 days before the day on which
2932 cancellation for nonpayment is effective, the coverage is extinguished as of the day on which
2933 the renewal premium is originally due.

2934 (iii) Delivery of the notice required by Subsection (2)(c)(iii), (2)(c)(iv), or (4)(b)(ii)(D)
2935 includes electronic delivery in accordance with Section 31A-21-316.

2936 (iv) An insurer is not subject to Subsection (4)(b)(ii)(D) if:

2937 (A) the insurer provides notice of the extinguishment of the right to renew for failure to
2938 pay premium at least 15 days, but no longer than 45 days, before the day on which the renewal
2939 payment is due; and

2940 (B) the policy is a personal lines policy.

2941 (v) Subsection (4)(b)(ii)(D) does not apply to a policy that provides coverage for 30

2942 days or less.

2943 (5) Notwithstanding Subsection (4), an insurer may not fail to renew the following

2944 personal lines insurance policies solely on the basis of:

2945 (a) in the case of a motor vehicle insurance policy:

2946 (i) a claim from the insured that:

2947 (A) results from an accident in which:

2948 (I) the insured is not at fault; and

2949 (II) the driver of the motor vehicle that is covered by the motor vehicle insurance

2950 policy is 21 years of age or older; and

2951 (B) is the only claim meeting the condition of Subsection (5)(a)(i)(A) within a

2952 36-month period;

2953 (ii) a single traffic violation by an insured that:

2954 (A) is a violation of a speed limit under Title 41, Chapter 6a, Traffic Code;

2955 (B) is not in excess of 10 miles per hour over the speed limit;

2956 (C) is not a traffic violation under:

2957 (I) Section 41-6a-601;

2958 (II) Section 41-6a-604; or

2959 (III) Section 41-6a-605;

2960 (D) is not a violation by an insured driver who is younger than 21 years of age; and

2961 (E) is the only violation meeting the conditions of Subsections (5)(a)(ii)(A) through

2962 (D) within a 36-month period; or

2963 (iii) a claim for damage that:

2964 (A) results solely from:

2965 (I) wind;

2966 (II) hail;

2967 (III) lightning; or

2968 (IV) an earthquake;

2969 (B) is not preventable by the exercise of reasonable care; and

2970 (C) is the only claim meeting the conditions of Subsections (5)(a)(iii)(A) and (B)
2971 within a 36-month period; and
2972 (b) in the case of a homeowner's insurance policy, a claim by the insured that is for
2973 damage that:
2974 (i) results solely from:
2975 (A) wind;
2976 (B) hail; or
2977 (C) lightning;
2978 (ii) is not preventable by the exercise of reasonable care; and
2979 (iii) is the only claim meeting the conditions of Subsections (5)(b)(i) and (ii) within a
2980 36-month period.
2981 (6) (a) (i) Subject to Subsection (6)(b), if the insurer offers or purports to renew the
2982 policy, but on less favorable terms or at higher rates, the new terms or rates take effect on the
2983 renewal date if the insurer delivered or sent by first-class mail to the policyholder notice of the
2984 new terms or rates at least 30 days before the day on which the previous policy expires.
2985 (ii) If the insurer did not give the prior notification described in Subsection (6)(a)(i) to
2986 the policyholder, the new terms or rates do not take effect until 30 days after the day on which
2987 the insurer delivers or sends by first-class mail the notice, in which case the policyholder may
2988 elect to cancel the renewal policy at any time during the 30-day period.
2989 (iii) Return premiums or additional premium charges shall be calculated
2990 proportionately on the basis that the old rates apply.
2991 (b) Except as provided in Subsection (6)(c), Subsection (6)(a) does not apply if the
2992 only change in terms that is adverse to the policyholder is:
2993 (i) a rate increase generally applicable to the class of business to which the policy
2994 belongs;
2995 (ii) a rate increase resulting from a classification change based on the altered nature or
2996 extent of the risk insured against; or
2997 (iii) a policy form change made to make the form consistent with Utah law.

2998 (c) Subsections (6)(b)(i) and (ii) do not apply to a rate increase of 25% or more on a
2999 commercial policy.
3000 (7) (a) If a notice of cancellation or nonrenewal under Subsection (2)(c) does not state
3001 with reasonable precision the facts on which the insurer's decision is based, the insurer shall
3002 send by first-class mail or deliver that information within 10 working days after receipt of a
3003 written request by the policyholder.
3004 (b) A notice under Subsection (2)(c) is not effective unless it contains information
3005 about the policyholder's right to make the request.
3006 (8) (a) An insurer that gives a notice of nonrenewal or cancellation of insurance on a
3007 motor vehicle insurance policy issued in accordance with the requirements of Chapter 22, Part
3008 3, Motor Vehicle Insurance, for nonpayment of a premium shall provide notice of nonrenewal
3009 or cancellation to a lienholder if the insurer has been provided the name and mailing address of
3010 the lienholder.
3011 (b) An insurer shall provide the notice described in Subsection (8)(a) to the lienholder
3012 by first-class mail or, if agreed by the parties, any electronic means of communication.
3013 (c) A lienholder shall provide a current physical address of notification or an electronic
3014 address of notification to an insurer that is required to make a notification under Subsection
3015 (8)(a).
3016 (9) If a risk-sharing plan under Section 31A-2-214 exists for the kind of coverage
3017 provided by the insurance being cancelled or nonrenewed, a notice of cancellation or
3018 nonrenewal required under Subsection (2)(c) or (4)(b)(i) may not be effective unless the notice
3019 contains instructions to the policyholder for applying for insurance through the available
3020 risk-sharing plan.
3021 (10) There is no liability on the part of, and no cause of action against, any insurer, its
3022 authorized representatives, agents, employees, or any other person furnishing to the insurer
3023 information relating to the reasons for cancellation or nonrenewal or for any statement made or
3024 information given by them in complying or enabling the insurer to comply with this section
3025 unless actual malice is proved by clear and convincing evidence.

3026 (11) This section does not alter any common law right of contract rescission for
3027 material misrepresentation.
3028 (12) If a person is required to pay a premium in accordance with this section:
3029 (a) the person may make the payment using:
3030 (i) the United States Postal Service;
3031 (ii) a delivery service the commissioner describes or designates by rule made in
3032 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; or
3033 (iii) electronic means; and
3034 (b) the payment is considered to be made:
3035 (i) for a payment that is mailed using the method described in Subsection (12)(a)(i), on
3036 the date on which the payment is postmarked;
3037 (ii) for a payment that is delivered using the method described in Subsection (12)(a)(ii),
3038 on the date on which the delivery service records or marks the payment as having been received
3039 by the delivery service; or
3040 (iii) for a payment that is made using the method described in Subsection (12)(a)(iii),
3041 on the date on which the payment is made electronically.
3042 Section 17. Section **31A-22-305.3** is amended to read:
3043 **31A-22-305.3. Underinsured motorist coverage.**
3044 (1) As used in this section:
3045 (a) "Covered person" has the same meaning as defined in Section 31A-22-305.
3046 (b) (i) "Underinsured motor vehicle" includes a motor vehicle, the operation,
3047 maintenance, or use of which is covered under a liability policy at the time of an injury-causing
3048 occurrence, but which has insufficient liability coverage to compensate fully the injured party
3049 for all special and general damages.
3050 (ii) The term "underinsured motor vehicle" does not include:
3051 (A) a motor vehicle that is covered under the liability coverage of the same policy that
3052 also contains the underinsured motorist coverage;
3053 (B) an uninsured motor vehicle as defined in Subsection 31A-22-305(2);

3054 (C) a motor vehicle owned or leased by:
3055 (I) a named insured;
3056 (II) a named insured's spouse; or
3057 (III) a dependent of a named insured.
3058 (2) (a) Underinsured motorist coverage under Subsection 31A-22-302(1)(c) provides
3059 coverage for a covered person who is legally entitled to recover damages from an owner or
3060 operator of an underinsured motor vehicle because of bodily injury, sickness, disease, or death.
3061 (b) A covered person occupying or using a motor vehicle owned, leased, or furnished
3062 to the covered person, the covered person's spouse, or covered person's resident relative may
3063 recover underinsured benefits only if the motor vehicle is:
3064 (i) described in the policy under which a claim is made; or
3065 (ii) a newly acquired or replacement motor vehicle covered under the terms of the
3066 policy.
3067 (3) (a) For purposes of this Subsection (3), "new policy" means:
3068 (i) any policy that is issued that does not include a renewal or reinstatement of an
3069 existing policy; or
3070 (ii) a change to an existing policy that results in:
3071 (A) a named insured being added to or deleted from the policy; or
3072 (B) a change in the limits of the named insured's motor vehicle liability coverage.
3073 (b) For new policies written on or after January 1, 2001, the limits of underinsured
3074 motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle
3075 liability coverage or the maximum underinsured motorist coverage limits available by the
3076 insurer under the named insured's motor vehicle policy, unless a named insured rejects or
3077 purchases coverage in a lesser amount by signing an acknowledgment form that:
3078 (i) is filed with the department;
3079 (ii) is provided by the insurer;
3080 (iii) waives the higher coverage;
3081 (iv) need only state in this or similar language that "underinsured motorist coverage

3082 provides benefits or protection to you and other covered persons for bodily injury resulting
3083 from an accident caused by the fault of another party where the other party has insufficient
3084 liability insurance"; and
3085 (v) discloses the additional premiums required to purchase underinsured motorist
3086 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle
3087 liability coverage or the maximum underinsured motorist coverage limits available by the
3088 insurer under the named insured's motor vehicle policy.
3089 (c) Any selection or rejection under Subsection (3)(b) continues for that issuer of the
3090 liability coverage until the insured requests, in writing, a change of underinsured motorist
3091 coverage from that liability insurer.
3092 (d) (i) Subsections (3)(b) and (c) apply retroactively to any claim arising on or after
3093 January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for
3094 arbitration or filed a complaint in a court of competent jurisdiction.
3095 (ii) The Legislature finds that the retroactive application of Subsections (3)(b) and (c)
3096 clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.
3097 (e) (i) As used in this Subsection (3)(e), "additional motor vehicle" means a change
3098 that increases the total number of vehicles insured by the policy, and does not include
3099 replacement, substitute, or temporary vehicles.
3100 (ii) The adding of an additional motor vehicle to an existing personal lines or
3101 commercial lines policy does not constitute a new policy for purposes of Subsection (3)(a).
3102 (iii) If an additional motor vehicle is added to a personal lines policy where
3103 underinsured motorist coverage has been rejected, or where underinsured motorist limits are
3104 lower than the named insured's motor vehicle liability limits, the insurer shall provide a notice
3105 to a named insured within 30 days that:
3106 (A) in the same manner described in Subsection (3)(b)(iv), explains the purpose of
3107 underinsured motorist coverage; and
3108 (B) encourages the named insured to contact the insurance company or insurance
3109 producer for quotes as to the additional premiums required to purchase underinsured motorist

3110 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle
3111 liability coverage or the maximum underinsured motorist coverage limits available by the
3112 insurer under the named insured's motor vehicle policy.
3113 (f) A change in policy number resulting from any policy change not identified under
3114 Subsection (3)(a)(ii) does not constitute a new policy.
3115 (g) (i) Subsection (3)(a) applies retroactively to any claim arising on or after January 1,
3116 2001 for which, as of May 1, 2012, an insured has not made a written demand for arbitration or
3117 filed a complaint in a court of competent jurisdiction.
3118 (ii) The Legislature finds that the retroactive application of Subsection (3)(a):
3119 (A) does not enlarge, eliminate, or destroy vested rights; and
3120 (B) clarifies legislative intent.
3121 (h) A self-insured, including a governmental entity, may elect to provide underinsured
3122 motorist coverage in an amount that is less than its maximum self-insured retention under
3123 Subsections (3)(b) and (l) by issuing a declaratory memorandum or policy statement from the
3124 chief financial officer or chief risk officer that declares the:
3125 (i) self-insured entity's coverage level; and
3126 (ii) process for filing an underinsured motorist claim.
3127 (i) Underinsured motorist coverage may not be sold with limits that are less than:
3128 (i) $10,000 for one person in any one accident; and
3129 (ii) at least $20,000 for two or more persons in any one accident.
3130 (j) An acknowledgment under Subsection (3)(b) continues for that issuer of the
3131 underinsured motorist coverage until the named insured, in writing, requests different
3132 underinsured motorist coverage from the insurer.
3133 (k) (i) The named insured's underinsured motorist coverage, as described in Subsection
3134 (2), is secondary to the liability coverage of an owner or operator of an underinsured motor
3135 vehicle, as described in Subsection (1).
3136 (ii) Underinsured motorist coverage may not be set off against the liability coverage of
3137 the owner or operator of an underinsured motor vehicle, but shall be added to, combined with,

3138 or stacked upon the liability coverage of the owner or operator of the underinsured motor
3139 vehicle to determine the limit of coverage available to the injured person.
3140 (l) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for
3141 policies existing on that date, the insurer shall disclose in the same medium as the premium
3142 renewal notice, an explanation of:
3143 (A) the purpose of underinsured motorist coverage in the same manner as described in
3144 Subsection (3)(b)(iv); and
3145 (B) a disclosure of the additional premiums required to purchase underinsured motorist
3146 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle
3147 liability coverage or the maximum underinsured motorist coverage limits available by the
3148 insurer under the named insured's motor vehicle policy.
3149 (ii) The disclosure required under this Subsection (3)(l) shall be sent to all named
3150 insureds that carry underinsured motorist coverage limits in an amount less than the named
3151 insured's motor vehicle liability policy limits or the maximum underinsured motorist coverage
3152 limits available by the insurer under the named insured's motor vehicle policy.
3153 (m) For purposes of this Subsection (3), a notice or disclosure sent to a named insured
3154 in a household constitutes notice or disclosure to all insureds within the household.
3155 (4) (a) (i) Except as provided in this Subsection (4), a covered person injured in a
3156 motor vehicle described in a policy that includes underinsured motorist benefits may not elect
3157 to collect underinsured motorist coverage benefits from another motor vehicle insurance policy.
3158 (ii) The limit of liability for underinsured motorist coverage for two or more motor
3159 vehicles may not be added together, combined, or stacked to determine the limit of insurance
3160 coverage available to an injured person for any one accident.
3161 (iii) Subsection (4)(a)(ii) applies to all persons except a covered person described
3162 under Subsections (4)(b)(i) and (ii).
3163 (b) (i) A covered person injured as a pedestrian by an underinsured motor vehicle may
3164 recover underinsured motorist benefits under any one other policy in which they are described
3165 as a covered person.

3166 (ii) Except as provided in Subsection (4)(b)(iii), a covered person injured while
3167 occupying, using, or maintaining a motor vehicle that is not owned, leased, or furnished to the
3168 covered person, the covered person's spouse, or the covered person's resident parent or resident
3169 sibling, may also recover benefits under any one other policy under which the covered person is
3170 also a covered person.
3171 (iii) (A) A covered person may recover benefits from no more than two additional
3172 policies, one additional policy from each parent's household if the covered person is:
3173 (I) a dependent minor of parents who reside in separate households; and
3174 (II) injured while occupying or using a motor vehicle that is not owned, leased, or
3175 furnished to the covered person, the covered person's resident parent, or the covered person's
3176 resident sibling.
3177 (B) Each parent's policy under this Subsection (4)(b)(iii) is liable only for the
3178 percentage of the damages that the limit of liability of each parent's policy of underinsured
3179 motorist coverage bears to the total of both parents' underinsured coverage applicable to the
3180 accident.
3181 (iv) A covered person's recovery under any available policies may not exceed the full
3182 amount of damages.
3183 (v) Underinsured coverage on a motor vehicle occupied at the time of an accident is
3184 primary coverage, and the coverage elected by a person described under Subsections
3185 31A-22-305(1)(a), (b), and (c) is secondary coverage.
3186 (vi) The primary and the secondary coverage may not be set off against the other.
3187 (vii) A covered person as described under Subsection (4)(b)(i) or is entitled to the
3188 highest limits of underinsured motorist coverage under only one additional policy per
3189 household applicable to that covered person as a named insured, spouse, or relative.
3190 (viii) A covered injured person is not barred against making subsequent elections if
3191 recovery is unavailable under previous elections.
3192 (ix) (A) As used in this section, "interpolicy stacking" means recovering benefits for a
3193 single incident of loss under more than one insurance policy.

3194 (B) Except to the extent permitted by this Subsection (4), interpolicy stacking is
3195 prohibited for underinsured motorist coverage.
3196 (c) Underinsured motorist coverage:
3197 (i) does not cover any benefit paid or payable under Title 34A, Chapter 2, Workers'
3198 Compensation Act, except that the covered person is credited an amount described in
3199 Subsection 34A-2-106(5);
3200 (ii) may not be subrogated by a workers' compensation insurance carrier;
3201 (iii) may not be reduced by benefits provided by workers' compensation insurance;
3202 (iv) may be reduced by health insurance subrogation only after the covered person is
3203 made whole;
3204 (v) may not be collected for bodily injury or death sustained by a person:
3205 (A) while committing a violation of Section 41-1a-1314;
3206 (B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated
3207 in violation of Section 41-1a-1314; or
3208 (C) while committing a felony; and
3209 (vi) notwithstanding Subsection (4)(c)(v), may be recovered:
3210 (A) for a person [~~under 18 years of age~~] younger than 18 years old who is injured
3211 within the scope of Subsection (4)(c)(v), but is limited to medical and funeral expenses; or
3212 (B) by a law enforcement officer as defined in Section 53-13-103, who is injured
3213 within the course and scope of the law enforcement officer's duties.
3214 (5) The inception of the loss under Subsection 31A-21-313(1) for underinsured
3215 motorist claims occurs upon the date of the last liability policy payment.
3216 (6) An underinsured motorist insurer does not have a right of reimbursement against a
3217 person liable for the damages resulting from an injury-causing occurrence if the person's
3218 liability insurer has tendered the policy limit and the limits have been accepted by the claimant.
3219 (7) Except as otherwise provided in this section, a covered person may seek, subject to
3220 the terms and conditions of the policy, additional coverage under any policy:
3221 (a) that provides coverage for damages resulting from motor vehicle accidents; and

3222 (b) that is not required to conform to Section 31A-22-302.
3223 (8) (a) When a claim is brought by a named insured or a person described in
3224 Subsection 31A-22-305(1) and is asserted against the covered person's underinsured motorist
3225 carrier, the claimant may elect to resolve the claim:
3226 (i) by submitting the claim to binding arbitration; or
3227 (ii) through litigation.
3228 (b) Unless otherwise provided in the policy under which underinsured benefits are
3229 claimed, the election provided in Subsection (8)(a) is available to the claimant only, except that
3230 if the policy under which insured benefits are claimed provides that either an insured or the
3231 insurer may elect arbitration, the insured or the insurer may elect arbitration and that election to
3232 arbitrate shall stay the litigation of the claim under Subsection (8)(a)(ii).
3233 (c) Once a claimant elects to commence litigation under Subsection (8)(a)(ii), the
3234 claimant may not elect to resolve the claim through binding arbitration under this section
3235 without the written consent of the underinsured motorist coverage carrier.
3236 (d) For purposes of the statute of limitations applicable to a claim described in
3237 Subsection (8)(a), if the claimant does not elect to resolve the claim through litigation, the
3238 claim is considered filed when the claimant submits the claim to binding arbitration in
3239 accordance with this Subsection (8).
3240 (e) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to
3241 binding arbitration under Subsection (8)(a)(i) shall be resolved by a single arbitrator.
3242 (ii) All parties shall agree on the single arbitrator selected under Subsection (8)(e)(i).
3243 (iii) If the parties are unable to agree on a single arbitrator as required under Subsection
3244 (8)(e)(ii), the parties shall select a panel of three arbitrators.
3245 (f) If the parties select a panel of three arbitrators under Subsection (8)(e)(iii):
3246 (i) each side shall select one arbitrator; and
3247 (ii) the arbitrators appointed under Subsection (8)(f)(i) shall select one additional
3248 arbitrator to be included in the panel.
3249 (g) Unless otherwise agreed to in writing:

3250 (i) each party shall pay an equal share of the fees and costs of the arbitrator selected
3251 under Subsection (8)(e)(i); or
3252 (ii) if an arbitration panel is selected under Subsection (8)(e)(iii):
3253 (A) each party shall pay the fees and costs of the arbitrator selected by that party; and
3254 (B) each party shall pay an equal share of the fees and costs of the arbitrator selected
3255 under Subsection (8)(f)(ii).
3256 (h) Except as otherwise provided in this section or unless otherwise agreed to in
3257 writing by the parties, an arbitration proceeding conducted under this section is governed by
3258 Title 78B, Chapter 11, Utah Uniform Arbitration Act.
3259 (i) (i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f),
3260 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of
3261 Subsections (9)(a) through (c) are satisfied.
3262 (ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure
3263 shall be determined based on the claimant's specific monetary amount in the written demand
3264 for payment of uninsured motorist coverage benefits as required in Subsection (9)(a)(i)(A).
3265 (iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to
3266 arbitration claims under this part.
3267 (j) An issue of discovery shall be resolved by the arbitrator or the arbitration panel.
3268 (k) A written decision by a single arbitrator or by a majority of the arbitration panel
3269 constitutes a final decision.
3270 (l) (i) Except as provided in Subsection (9), the amount of an arbitration award may not
3271 exceed the underinsured motorist policy limits of all applicable underinsured motorist policies,
3272 including applicable underinsured motorist umbrella policies.
3273 (ii) If the initial arbitration award exceeds the underinsured motorist policy limits of all
3274 applicable underinsured motorist policies, the arbitration award shall be reduced to an amount
3275 equal to the combined underinsured motorist policy limits of all applicable underinsured
3276 motorist policies.
3277 (m) The arbitrator or arbitration panel may not decide an issue of coverage or

3278 extra-contractual damages, including:
3279 (i) whether the claimant is a covered person;
3280 (ii) whether the policy extends coverage to the loss; or
3281 (iii) an allegation or claim asserting consequential damages or bad faith liability.
3282 (n) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or
3283 class-representative basis.
3284 (o) If the arbitrator or arbitration panel finds that the arbitration is not brought, pursued,
3285 or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees
3286 and costs against the party that failed to bring, pursue, or defend the arbitration in good faith.
3287 (p) An arbitration award issued under this section shall be the final resolution of all
3288 claims not excluded by Subsection (8)(m) between the parties unless:
3289 (i) the award is procured by corruption, fraud, or other undue means; or
3290 (ii) either party, within 20 days after service of the arbitration award:
3291 (A) files a complaint requesting a trial de novo in the district court; and
3292 (B) serves the nonmoving party with a copy of the complaint requesting a trial de novo
3293 under Subsection (8)(p)(ii)(A).
3294 (q) (i) Upon filing a complaint for a trial de novo under Subsection (8)(p), a claim shall
3295 proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of
3296 Evidence in the district court.
3297 (ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may
3298 request a jury trial with a complaint requesting a trial de novo under Subsection (8)(p)(ii)(A).
3299 (r) (i) If the claimant, as the moving party in a trial de novo requested under Subsection
3300 (8)(p), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the
3301 arbitration award, the claimant is responsible for all of the nonmoving party's costs.
3302 (ii) If the underinsured motorist carrier, as the moving party in a trial de novo requested
3303 under Subsection (8)(p), does not obtain a verdict that is at least 20% less than the arbitration
3304 award, the underinsured motorist carrier is responsible for all of the nonmoving party's costs.
3305 (iii) Except as provided in Subsection (8)(r)(iv), the costs under this Subsection (8)(r)

3306 shall include:
3307 (A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and
3308 (B) the costs of expert witnesses and depositions.
3309 (iv) An award of costs under this Subsection (8)(r) may not exceed $2,500 unless
3310 Subsection (9)(h)(iii) applies.
3311 (s) For purposes of determining whether a party's verdict is greater or less than the
3312 arbitration award under Subsection (8)(r), a court may not consider any recovery or other relief
3313 granted on a claim for damages if the claim for damages:
3314 (i) was not fully disclosed in writing prior to the arbitration proceeding; or
3315 (ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil
3316 Procedure.
3317 (t) If a district court determines, upon a motion of the nonmoving party, that a moving
3318 party's use of the trial de novo process is filed in bad faith in accordance with Section
3319 78B-5-825, the district court may award reasonable attorney fees to the nonmoving party.
3320 (u) Nothing in this section is intended to limit a claim under another portion of an
3321 applicable insurance policy.
3322 (v) If there are multiple underinsured motorist policies, as set forth in Subsection (4),
3323 the claimant may elect to arbitrate in one hearing the claims against all the underinsured
3324 motorist carriers.
3325 (9) (a) Within 30 days after a covered person elects to submit a claim for underinsured
3326 motorist benefits to binding arbitration or files litigation, the covered person shall provide to
3327 the underinsured motorist carrier:
3328 (i) a written demand for payment of underinsured motorist coverage benefits, setting
3329 forth:
3330 (A) subject to Subsection (9)(l), the specific monetary amount of the demand,
3331 including a computation of the covered person's claimed past medical expenses, claimed past
3332 lost wages, and all other claimed past economic damages; and
3333 (B) the factual and legal basis and any supporting documentation for the demand;

3334 (ii) a written statement under oath disclosing:
3335 (A) (I) the names and last known addresses of all health care providers who have
3336 rendered health care services to the covered person that are material to the claims for which the
3337 underinsured motorist benefits are sought for a period of five years preceding the date of the
3338 event giving rise to the claim for underinsured motorist benefits up to the time the election for
3339 arbitration or litigation has been exercised; and
3340 (II) the names and last known addresses of the health care providers who have rendered
3341 health care services to the covered person, which the covered person claims are immaterial to
3342 the claims for which underinsured motorist benefits are sought, for a period of five years
3343 preceding the date of the event giving rise to the claim for underinsured motorist benefits up to
3344 the time the election for arbitration or litigation has been exercised that have not been disclosed
3345 under Subsection (9)(a)(ii)(A)(I);
3346 (B) (I) the names and last known addresses of all health insurers or other entities to
3347 whom the covered person has submitted claims for health care services or benefits material to
3348 the claims for which underinsured motorist benefits are sought, for a period of five years
3349 preceding the date of the event giving rise to the claim for underinsured motorist benefits up to
3350 the time the election for arbitration or litigation has been exercised; and
3351 (II) the names and last known addresses of the health insurers or other entities to whom
3352 the covered person has submitted claims for health care services or benefits, which the covered
3353 person claims are immaterial to the claims for which underinsured motorist benefits are sought,
3354 for a period of five years preceding the date of the event giving rise to the claim for
3355 underinsured motorist benefits up to the time the election for arbitration or litigation have not
3356 been disclosed;
3357 (C) if lost wages, diminished earning capacity, or similar damages are claimed, all
3358 employers of the covered person for a period of five years preceding the date of the event
3359 giving rise to the claim for underinsured motorist benefits up to the time the election for
3360 arbitration or litigation has been exercised;
3361 (D) other documents to reasonably support the claims being asserted; and

3362 (E) all state and federal statutory lienholders including a statement as to whether the
3363 covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health
3364 Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act,
3365 or if the claim is subject to any other state or federal statutory liens; and
3366 (iii) signed authorizations to allow the underinsured motorist carrier to only obtain
3367 records and billings from the individuals or entities disclosed under Subsections
3368 (9)(a)(ii)(A)(I), (B)(I), and (C).
3369 (b) (i) If the underinsured motorist carrier determines that the disclosure of undisclosed
3370 health care providers or health care insurers under Subsection (9)(a)(ii) is reasonably necessary,
3371 the underinsured motorist carrier may:
3372 (A) make a request for the disclosure of the identity of the health care providers or
3373 health care insurers; and
3374 (B) make a request for authorizations to allow the underinsured motorist carrier to only
3375 obtain records and billings from the individuals or entities not disclosed.
3376 (ii) If the covered person does not provide the requested information within 10 days:
3377 (A) the covered person shall disclose, in writing, the legal or factual basis for the
3378 failure to disclose the health care providers or health care insurers; and
3379 (B) either the covered person or the underinsured motorist carrier may request the
3380 arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be
3381 provided if the covered person has elected arbitration.
3382 (iii) The time periods imposed by Subsection (9)(c)(i) are tolled pending resolution of
3383 the dispute concerning the disclosure and production of records of the health care providers or
3384 health care insurers.
3385 (c) (i) An underinsured motorist carrier that receives an election for arbitration or a
3386 notice of filing litigation and the demand for payment of underinsured motorist benefits under
3387 Subsection (9)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the
3388 demand and receipt of the items specified in Subsections (9)(a)(i) through (iii), to:
3389 (A) provide a written response to the written demand for payment provided for in

3390 Subsection (9)(a)(i);

3391 (B) except as provided in Subsection (9)(c)(i)(C), tender the amount, if any, of the

3392 underinsured motorist carrier's determination of the amount owed to the covered person; and

3393 (C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah

3394 Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's

3395 Health Insurance Act, or if the claim is subject to any other state or federal statutory liens,

3396 tender the amount, if any, of the underinsured motorist carrier's determination of the amount

3397 owed to the covered person less:

3398 (I) if the amount of the state or federal statutory lien is established, the amount of the

3399 lien; or

3400 (II) if the amount of the state or federal statutory lien is not established, two times the

3401 amount of the medical expenses subject to the state or federal statutory lien until such time as

3402 the amount of the state or federal statutory lien is established.

3403 (ii) If the amount tendered by the underinsured motorist carrier under Subsection

3404 (9)(c)(i) is the total amount of the underinsured motorist policy limits, the tendered amount

3405 shall be accepted by the covered person.

3406 (d) A covered person who receives a written response from an underinsured motorist

3407 carrier as provided for in Subsection (9)(c)(i), may:

3408 (i) elect to accept the amount tendered in Subsection (9)(c)(i) as payment in full of all

3409 underinsured motorist claims; or

3410 (ii) elect to:

3411 (A) accept the amount tendered in Subsection (9)(c)(i) as partial payment of all

3412 underinsured motorist claims; and

3413 (B) continue to litigate or arbitrate the remaining claim in accordance with the election

3414 made under Subsections (8)(a), (b), and (c).

3415 (e) If a covered person elects to accept the amount tendered under Subsection (9)(c)(i)

3416 as partial payment of all underinsured motorist claims, the final award obtained through

3417 arbitration, litigation, or later settlement shall be reduced by any payment made by the

3418 underinsured motorist carrier under Subsection (9)(c)(i).

3419 (f) In an arbitration proceeding on the remaining underinsured claims:

3420 (i) the parties may not disclose to the arbitrator or arbitration panel the amount paid

3421 under Subsection (9)(c)(i) until after the arbitration award has been rendered; and

3422 (ii) the parties may not disclose the amount of the limits of underinsured motorist

3423 benefits provided by the policy.

3424 (g) If the final award obtained through arbitration or litigation is greater than the

3425 average of the covered person's initial written demand for payment provided for in Subsection

3426 (9)(a)(i) and the underinsured motorist carrier's initial written response provided for in

3427 Subsection (9)(c)(i), the underinsured motorist carrier shall pay:

3428 (i) the final award obtained through arbitration or litigation, except that if the award

3429 exceeds the policy limits of the subject underinsured motorist policy by more than $15,000, the

3430 amount shall be reduced to an amount equal to the policy limits plus $15,000; and

3431 (ii) any of the following applicable costs:

3432 (A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

3433 (B) the arbitrator or arbitration panel's fee; and

3434 (C) the reasonable costs of expert witnesses and depositions used in the presentation of

3435 evidence during arbitration or litigation.

3436 (h) (i) The covered person shall provide an affidavit of costs within five days of an

3437 arbitration award.

3438 (ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to

3439 which the underinsured motorist carrier objects.

3440 (B) The objection shall be resolved by the arbitrator or arbitration panel.

3441 (iii) The award of costs by the arbitrator or arbitration panel under Subsection (9)(g)(ii)

3442 may not exceed $5,000.

3443 (i) (i) A covered person shall disclose all material information, other than rebuttal

3444 evidence, within 30 days after a covered person elects to submit a claim for underinsured

3445 motorist coverage benefits to binding arbitration or files litigation as specified in Subsection

3446 (9)(a).

3447 (ii) If the information under Subsection (9)(i)(i) is not disclosed, the covered person
3448 may not recover costs or any amounts in excess of the policy under Subsection (9)(g).

3449 (j) This Subsection (9) does not limit any other cause of action that arose or may arise
3450 against the underinsured motorist carrier from the same dispute.

3451 (k) The provisions of this Subsection (9) only apply to motor vehicle accidents that
3452 occur on or after March 30, 2010.

3453 (l) (i) The written demand requirement in Subsection (9)(a)(i)(A) does not affect the
3454 covered person's requirement to provide a computation of any other economic damages
3455 claimed, and the one or more respondents shall have a reasonable time after the receipt of the
3456 computation of any other economic damages claimed to conduct fact and expert discovery as to
3457 any additional damages claimed. The changes made by Laws of Utah 2014, Chapter 290,
3458 Section 11, and Chapter 300, Section 11, to this Subsection (9)(l) and Subsection (9)(a)(i)(A)
3459 apply to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

3460 (ii) The changes made by Laws of Utah 2014, Chapter 290, Section 11, and Chapter
3461 300, Section 11, under Subsections (9)(a)(ii)(A)(II) and (B)(II) apply to a claim submitted to
3462 binding arbitration or through litigation on or after May 13, 2014.

3463 Section 18. Section **31A-22-602** is amended to read:

3464 **31A-22-602. Premium rates.**

3465 (1) Except as provided in Subsection 31A-22-701(4), this section does not apply to
3466 group accident and health insurance.

3467 (2) The benefits in an accident and health insurance policy shall be reasonable in
3468 relation to the premiums charged.

3469 (3) The commissioner shall prohibit the use of [~~a policy offering~~] an accident and
3470 health insurance form or rates if the form or rates do not satisfy Subsection (2).

3471 Section 19. Section **31A-22-618.6** is amended to read:

3472 **31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit**
3473 **plans.**

3474 (1) Except as otherwise provided in this section, a group health benefit plan for a plan
3475 sponsor is renewable and continues in force:
3476 (a) with respect to all eligible employees and dependents; and
3477 (b) at the option of the plan sponsor.
3478 (2) A group health benefit plan for a plan sponsor may be discontinued or nonrenewed:
3479 (a) for noncompliance with the insurer's employer contribution requirements;
3480 (b) if there is no longer any enrollee under the group health benefit plan who lives,
3481 resides, or works in:
3482 (i) the service area of the insurer; or
3483 (ii) the area for which the insurer is authorized to do business;
3484 (c) for coverage made available in the small or large employer market only through an
3485 association, if:
3486 (i) the employer's membership in the association ceases; and
3487 (ii) the coverage is [~~terminated~~] discontinued or nonrenewed uniformly without regard
3488 to any health status-related factor relating to any covered individual; or
3489 (d) for noncompliance with the insurer's minimum employee participation
3490 requirements, except as provided in Subsection (3).
3491 (3) If a small employer no longer employs at least one eligible employee, a carrier may
3492 not discontinue or not renew the group health benefit plan until the first renewal date following
3493 the beginning of a new plan year, even if the carrier knows at the beginning of the plan year
3494 that the employer no longer has at least one eligible employee.
3495 (4) (a) A small employer that, after purchasing a group health benefit plan in the small
3496 group market, employs on average more than 50 eligible employees on each business day in a
3497 calendar year may continue to renew the group health benefit plan purchased in the small group
3498 market.
3499 (b) A large employer that, after purchasing a group health benefit plan in the large
3500 group market, employs on average fewer than 51 eligible employees on each business day in a
3501 calendar year may continue to renew the group health benefit plan purchased in the large group

3502 market.

3503 (5) A health benefit plan for a plan sponsor may be discontinued or nonrenewed if:

3504 (a) a condition described in Subsection (2) exists;

3505 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
3506 terms of the contract;

3507 (c) the plan sponsor:

3508 (i) performs an act or practice that constitutes fraud; or

3509 (ii) makes an intentional misrepresentation of material fact under the terms of the
3510 coverage;

3511 (d) the insurer:

3512 (i) elects to discontinue offering a particular group health benefit plan delivered or
3513 issued for delivery in this state;

3514 (ii) provides notice of the discontinuation in writing to each plan sponsor, employee,
3515 and dependent of an employee, at least 90 days before the day on which the coverage
3516 discontinues;

3517 (iii) provides notice of the discontinuation in writing to the commissioner, and at least
3518 three working days before the day on which the notice is sent to each affected plan sponsor,
3519 employee, and dependent of an employee;

3520 (iv) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all
3521 other group health benefit plans currently being offered by the insurer in the market or, in the
3522 case of a large employer, any other group health benefit plans currently being offered in that
3523 market; and

3524 (v) in exercising the option to discontinue [~~that~~] the group health benefit plan and in
3525 offering the option of coverage in this section, acts uniformly without regard to the claims
3526 experience of a plan sponsor, any health status-related factor relating to any covered participant
3527 or beneficiary, or any health status-related factor relating to any new participant or beneficiary
3528 who may become eligible for the coverage; or

3529 (e) the insurer:

3530 (i) elects to discontinue offering all of the insurer's group health benefit plans in:
3531 (A) the small employer market;
3532 (B) the large employer market; or
3533 (C) both the small employer and large employer markets;
3534 (ii) provides notice of the discontinuation in writing to each plan sponsor, employee,
3535 and dependent of an employee at least 180 days before the day on which the coverage
3536 discontinues;
3537 (iii) provides notice of the discontinuation in writing to the commissioner in each state
3538 in which an affected insured individual is known to reside and, at least 30 working days before
3539 the day on which the notice is sent to each affected plan sponsor, employee, and dependent of
3540 an employee;
3541 (iv) discontinues and nonrenews all plans issued or delivered for issuance in the market
3542 described in Subsection (5)(e)(i); and
3543 (v) (A) provides a plan of orderly withdrawal as required by Section 31A-4-115[.]; or
3544 (B) places the plan with an affiliate of the insurer with a plan of the same or similar
3545 coverage.
3546 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
3547 discontinued if after issuance of coverage the eligible employee:
3548 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
3549 or
3550 (ii) makes an intentional misrepresentation of material fact in connection with the
3551 coverage.
3552 (b) An eligible employee whose coverage is discontinued under Subsection (6)(a) may
3553 reenroll:
3554 (i) 12 months after the day on which the employee's coverage discontinues; and
3555 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
3556 to reenroll.
3557 (c) At the time the eligible employee's coverage discontinues under Subsection (6)(a),

3558 the insurer shall notify the eligible employee of the right to reenroll as described in Subsection
3559 (6)(b).
3560 (d) An eligible employee's coverage may not be discontinued under this Subsection (6)
3561 because of a fraud or misrepresentation that relates to health status.
3562 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
3563 the employer:
3564 (a) with respect to coverage provided to an employer member of the association; and
3565 (b) if the group health benefit plan is made available by an insurer in the employer
3566 market only through:
3567 (i) an association;
3568 (ii) a trust; or
3569 (iii) a discretionary group.
3570 (8) An insurer may modify a group health benefit plan for a plan sponsor only:
3571 (a) at the time of coverage renewal; and
3572 (b) if the modification is effective uniformly among all plans [~~with that product~~].
3573 Section 20. Section **31A-22-618.7** is amended to read:
3574 **31A-22-618.7. Discontinuance, nonrenewal, and modification for individual**
3575 **health benefit plans.**
3576 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an
3577 individual basis is renewable and continues in force:
3578 (i) with respect to all enrollees or dependents; and
3579 (ii) at the option of the enrollee.
3580 (b) Subsection (1)(a) applies regardless of:
3581 (i) whether the contract is issued through:
3582 (A) a trust;
3583 (B) an association;
3584 (C) a discretionary group; or
3585 (D) other similar grouping; or

3586 (ii) the situs of delivery of the policy or contract.

3587 (2) An individual health benefit plan may be discontinued or nonrenewed:

3588 (a) if:

3589 (i) there is no longer an enrollee under the individual health benefit plan who lives,

3590 resides, or works in:

3591 (A) the service area of the insurer; or

3592 (B) the area for which the insurer is authorized to do business; and

3593 (ii) coverage is [~~terminated~~] discontinued or nonrenewed uniformly without regard to

3594 any health status-related factor relating to any covered enrollee; or

3595 (b) for coverage made available through an association, if:

3596 (i) the enrollee's membership in the association ceases; and

3597 (ii) the coverage is [~~terminated~~] discontinued or nonrenewed uniformly without regard

3598 to any health status-related factor relating to any covered enrollee.

3599 (3) An individual health benefit plan may be discontinued or nonrenewed if:

3600 (a) a condition described in Subsection (2) exists;

3601 (b) the enrollee fails to pay premiums or contributions in accordance with the terms of

3602 the health benefit plan, including any timeliness requirements;

3603 (c) the enrollee:

3604 (i) performs an act or practice in connection with the coverage that constitutes fraud; or

3605 (ii) makes an intentional misrepresentation of material fact under the terms of the

3606 coverage;

3607 (d) the insurer:

3608 (i) elects to discontinue offering a particular individual health benefit plan [~~product~~]

3609 delivered or issued for delivery in this state; and

3610 (ii) (A) provides notice of the discontinuation in writing to each enrollee provided

3611 coverage at least 90 days before the day on which the coverage discontinues;

3612 (B) provides notice of the discontinuation in writing to the commissioner and, at least

3613 three working days before the day on which the notice is sent, to each affected enrollee;

3614 (C) offers to each covered enrollee on a guaranteed issue basis the option to purchase
3615 all other individual health benefit plans currently being offered by the insurer for individuals in
3616 that market; and
3617 (D) acts uniformly without regard to any health status-related factor of covered
3618 enrollees or dependents of covered enrollees who may become eligible for coverage; or
3619 (e) the insurer:
3620 (i) elects to discontinue offering all of the insurer's individual health benefit plans in
3621 the individual market; [and]
3622 (ii) [(A)] provides notice of the discontinuation in writing to each enrollee provided
3623 coverage at least 180 days before the day on which the coverage discontinues;
3624 [(B)] (iii) provides notice of the discontinuation in writing to the commissioner in each
3625 state in which an affected enrollee is known to reside and, at least 30 working days before the
3626 day on which the insurer sends the notice, to each affected enrollee;
3627 [(C)] (iv) discontinues and nonrenews all individual health benefit plans the insurer
3628 issues or delivers for issuance in the individual market; [and]
3629 [(D)] (v) acts uniformly without regard to any health status-related factor of covered
3630 enrollees or dependents of covered enrollees who may become eligible for coverage[.]; and
3631 (vi) (A) provides a plan of orderly withdrawal in accordance with Section 31A-4-115;
3632 or
3633 (B) places the plan with an affiliate of the insurer with a plan of the same or similar
3634 coverage.
3635 (4) An insurer may modify an individual health benefit plan only:
3636 (a) at the time of coverage renewal; and
3637 (b) if the modification is effective uniformly among all individual health benefit plans.
3638 Section 21. Section **31A-22-618.8** is amended to read:
3639 **31A-22-618.8. Discontinuance and nonrenewal limitations for health benefit**
3640 **plans.**
3641 (1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health

3642 benefit plan under [Subsections] Subsection 31A-22-618.6(5)(e) [and] or 31A-22-618.7(3)(e)
3643 is prohibited from writing new business:
3644 (a) in the market in this state for which the insurer discontinues or does not renew; and
3645 (b) for a period of five years beginning on the day on which the last coverage that is
3646 discontinued.
3647 (2) If an insurer is doing business in one established geographic service area of the
3648 state, [Sections] Subsections 31A-22-618.6(5)(e) and 31A-22-618.7(3)(e) apply only to the
3649 insurer's operations in that service area.
3650 (3) The commissioner may, by rule or order, define the scope of service area.
3651 Section 22. Section **31A-22-627** is amended to read:
3652 **31A-22-627. Coverage of emergency medical services.**
3653 (1) A health insurance policy or managed care organization contract:
3654 (a) shall provide coverage of emergency services; and
3655 (b) may not:
3656 (i) require any form of preauthorization for treatment of an emergency medical
3657 condition until after the insured's condition has been stabilized;
3658 (ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered
3659 treatment considered medically necessary to stabilize the emergency medical condition of an
3660 insured; or
3661 (iii) impose any cost-sharing requirement for out-of-network that exceeds the
3662 cost-sharing requirement imposed for in-network.
3663 (2) (a) A health insurance policy or managed care organization contract may require
3664 authorization for the continued treatment of an emergency medical condition after the insured's
3665 condition has been stabilized.
3666 (b) If authorization described in Subsection (2)(a) is required, an insurer who does not
3667 accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic
3668 testing, or other treatment considered medically necessary that occurred between the time the
3669 request was received and the time the insurer rejected the request for authorization.

3670 (3) For purposes of this section:

3671 [~~(a) "Emergency medical condition" means a medical condition manifesting itself by~~
3672 ~~acute symptoms of sufficient severity, including severe pain, such that a prudent layperson,~~
3673 ~~who possesses an average knowledge of medicine and health, would reasonably expect the~~
3674 ~~absence of immediate medical attention through a hospital emergency department to result in:~~]

3675 [~~(i) placing the insured's health, or with respect to a pregnant woman, the health of the~~
3676 ~~woman or her unborn child, in serious jeopardy;~~]

3677 [~~(ii) serious impairment to bodily functions; or~~]

3678 [~~(iii) serious dysfunction of any bodily organ or part.~~]

3679 [~~(b)~~] (a) "Hospital emergency department" means that area of a hospital in which
3680 emergency services are provided on a 24-hour-a-day basis.

3681 [~~(c)~~] (b) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec.
3682 1395dd(e)(3).

3683 (4) Nothing in this section may be construed as:

3684 (a) altering the level or type of benefits that are provided under the terms of a contract
3685 or policy; or

3686 (b) restricting a policy or contract from providing enhanced benefits for certain
3687 emergency medical conditions that are identified in the policy or contract.

3688 (5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has
3689 violated this section, the commissioner may:

3690 (a) work with the insurer to improve the insurer's compliance with this section; or

3691 (b) impose the following fines:

3692 (i) not more than $5,000; or

3693 (ii) twice the amount of any profit gained from violations of this section.

3694 Section 23. Section **31A-22-636** is amended to read:

3695 **31A-22-636. Standardized health insurance information cards.**

3696 (1) As used in this section, "insurer" means:

3697 (a) an insurer governed by this part as described in Section 31A-22-600;

3698 (b) a health maintenance organization governed by Chapter 8, Health Maintenance
3699 Organizations and Limited Health Plans;
3700 (c) a third party administrator; and
3701 (d) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health,
3702 medical, or conversion policy offered under Title 49, Chapter 20, Public Employees' Benefit
3703 and Insurance Program Act.
3704 (2) In accordance with Subsection (3), an insurer shall use and issue a health benefit
3705 plan information card for the insurer's enrollees upon the purchase or renewal of, or enrollment
3706 in, a health benefit plan [~~on or after July 1, 2010~~].
3707 (3) The health benefit plan information card shall include:
3708 (a) the covered person's name;
3709 (b) the name of the carrier and the carrier network name;
3710 (c) the contact information for the carrier or health benefit plan administrator;
3711 (d) general information regarding copayments and deductibles; and
3712 (e) an indication of whether the health benefit plan is regulated by the state.
3713 (4) (a) The commissioner shall work with the Department of Health, the Health Data
3714 Authority, health care providers groups, and with state and national organizations that [~~are~~
3715 ~~developing~~] develop uniform standards for the electronic exchange of health insurance claims
3716 or uniform standards for the electronic exchange of clinical health records.
3717 (b) [~~When the commissioner determines that the groups described in Subsection (4)(a)~~
3718 ~~have reached a consensus regarding the electronic technology and standards necessary to~~
3719 ~~electronically exchange insurance enrollment and coverage information, the commissioner~~
3720 ~~shall begin the rulemaking process under~~] The commissioner may make rules in accordance
3721 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt standardized
3722 electronic interchange technology.
3723 (c) After rules are adopted under Subsection (4)(a), health care providers and their
3724 licensing boards under Title 58, Occupations and Professions, and health facilities licensed
3725 under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, shall work

3726 together to implement the adoption of card swipe technology.

3727 Section 24. Section **31A-22-657** is enacted to read:

3728 **31A-22-657. Application of health insurance mandates.**

3729 (1) As used in this section:

3730 (a) "Cost-sharing requirement" means a copayment, coinsurance, or deductible

3731 required by or on behalf of an enrollee in order to receive a benefit under a qualified

3732 high-deductible health plan.

3733 (b) "Health savings account" means the same as that term is defined in 26 U.S.C. Sec.

3734 223(d)(1).

3735 (c) "Qualified high-deductible health plan" means a high-deductible health plan as

3736 defined in 26 U.S.C. Sec. 223(c)(2)(A) that is used in conjunction with a health savings

3737 account.

3738 (d) "Cost-sharing mandate" means a statutory requirement limiting a cost-sharing

3739 requirement.

3740 (2) (a) Except as provided in Subsection (2)(b), if under federal law, a cost-sharing

3741 mandate would result in an enrollee becoming ineligible for a health savings account, the

3742 cost-sharing mandate applies only to the enrollee's qualified high-deductible health plan after

3743 the enrollee satisfies the enrollee's health plan deductible.

3744 (b) Subsection (2)(a) does not apply to an item or service that is preventive care under

3745 26 U.S.C. Sec. 223(c)(2)(C).

3746 Section 25. Section **31A-22-727** is enacted to read:

3747 **31A-22-727. Renewal, cancellation, and modification.**

3748 (1) Except as provided in Section 31A-22-618.6, for a group insurance policy offering

3749 accident and health insurance or a blanket insurance policy offering accident and health

3750 insurance, an insurer may:

3751 (a) decline to renew the policy on the date the policy term expires for a reason stated in

3752 the policy; or

3753 (b) cancel the policy at any time for:

3754 (i) nonpayment of a premium when due;
3755 (ii) intentional misrepresentation of a material fact in connection with the coverage;
3756 (iii) performance of an act or practice that constitutes fraud in connection with the
3757 coverage; or
3758 (iv) noncompliance with an employer eligibility provision.
3759 (2) Except for a modification required by law, an insurer may only modify a policy at
3760 renewal.
3761 (3) Subsection (2) does not apply to an endorsement by which the insurer:
3762 (a) effectuates a request the policyholder made in writing; or
3763 (b) exercises a specifically reserved right under the policy.
3764 Section 26. Section **31A-23a-111** is amended to read:
3765 **31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
3766 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**
3767 (1) A license type issued under this chapter remains in force until:
3768 (a) revoked or suspended under Subsection (5);
3769 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
3770 administrative action;
3771 (c) the licensee dies or is adjudicated incompetent as defined under:
3772 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3773 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3774 Minors;
3775 (d) lapsed under Section 31A-23a-113; or
3776 (e) voluntarily surrendered.
3777 (2) The following may be reinstated within one year after the day on which the license
3778 is no longer in force:
3779 (a) a lapsed license; or
3780 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
3781 not be reinstated after the license period in which the license is voluntarily surrendered.

3782 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
3783 license, submission and acceptance of a voluntary surrender of a license does not prevent the
3784 department from pursuing additional disciplinary or other action authorized under:
3785 (a) this title; or
3786 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
3787 Administrative Rulemaking Act.
3788 (4) A line of authority issued under this chapter remains in force until:
3789 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;
3790 or
3791 (b) the supporting license type:
3792 (i) is revoked or suspended under Subsection (5);
3793 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
3794 administrative action;
3795 (iii) lapses under Section 31A-23a-113; or
3796 (iv) is voluntarily surrendered; or
3797 (c) the licensee dies or is adjudicated incompetent as defined under:
3798 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3799 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3800 Minors.
3801 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an
3802 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
3803 commissioner may:
3804 (i) revoke:
3805 (A) a license; or
3806 (B) a line of authority;
3807 (ii) suspend for a specified period of 12 months or less:
3808 (A) a license; or
3809 (B) a line of authority;

3810 (iii) limit in whole or in part:
3811 (A) a license; or
3812 (B) a line of authority;
3813 (iv) deny a license application;
3814 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
3815 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and
3816 Subsection (5)(a)(v).
3817 (b) The commissioner may take an action described in Subsection (5)(a) if the
3818 commissioner finds that the licensee or license applicant:
3819 (i) is unqualified for a license or line of authority under Section 31A-23a-104,
3820 31A-23a-105, or 31A-23a-107;
3821 (ii) violates:
3822 (A) an insurance statute;
3823 (B) a rule that is valid under Subsection 31A-2-201(3); or
3824 (C) an order that is valid under Subsection 31A-2-201(4);
3825 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
3826 delinquency proceedings in any state;
3827 (iv) fails to pay a final judgment rendered against the person [~~in this state~~] within 60
3828 days after the day on which the judgment became final;
3829 (v) fails to meet the same good faith obligations in claims settlement that is required of
3830 admitted insurers;
3831 (vi) is affiliated with and under the same general management or interlocking
3832 directorate or ownership as another insurance producer that transacts business in this state
3833 without a license;
3834 (vii) refuses:
3835 (A) to be examined; or
3836 (B) to produce its accounts, records, and files for examination;
3837 (viii) has an officer who refuses to:

3838 (A) give information with respect to the insurance producer's affairs; or
3839 (B) perform any other legal obligation as to an examination;
3840 (ix) provides information in the license application that is:
3841 (A) incorrect;
3842 (B) misleading;
3843 (C) incomplete; or
3844 (D) materially untrue;
3845 (x) violates an insurance law, valid rule, or valid order of another regulatory agency in
3846 any jurisdiction;
3847 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
3848 (xii) improperly withholds, misappropriates, or converts money or properties received
3849 in the course of doing insurance business;
3850 (xiii) intentionally misrepresents the terms of an actual or proposed:
3851 (A) insurance contract;
3852 (B) application for insurance; or
3853 (C) life settlement;
3854 (xiv) has been convicted of:
3855 (A) a felony; or
3856 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
3857 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
3858 (xvi) in the conduct of business in this state or elsewhere:
3859 (A) uses fraudulent, coercive, or dishonest practices; or
3860 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
3861 (xvii) has had an insurance license or other professional or occupational license, or an
3862 equivalent to an insurance license or registration, or other professional or occupational license
3863 or registration:
3864 (A) denied;
3865 (B) suspended;

3866 (C) revoked; or
3867 (D) surrendered to resolve an administrative action;
3868 (xviii) forges another's name to:
3869 (A) an application for insurance; or
3870 (B) a document related to an insurance transaction;
3871 (xix) improperly uses notes or another reference material to complete an examination
3872 for an insurance license;
3873 (xx) knowingly accepts insurance business from an individual who is not licensed;
3874 (xxi) fails to comply with an administrative or court order imposing a child support
3875 obligation;
3876 (xxii) fails to:
3877 (A) pay state income tax; or
3878 (B) comply with an administrative or court order directing payment of state income
3879 tax;
3880 (xxiii) has been convicted of violating the federal Violent Crime Control and Law
3881 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage
3882 in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;
3883 (xxiv) engages in a method or practice in the conduct of business that endangers the
3884 legitimate interests of customers and the public; or
3885 (xxv) has been convicted of any criminal felony involving dishonesty or breach of trust
3886 and has not obtained written consent to engage in the business of insurance or participate in
3887 such business as required by 18 U.S.C. Sec. 1033.
3888 (c) For purposes of this section, if a license is held by an agency, both the agency itself
3889 and any individual designated under the license are considered to be the holders of the license.
3890 (d) If an individual designated under the agency license commits an act or fails to
3891 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
3892 the commissioner may suspend, revoke, or limit the license of:
3893 (i) the individual;

3894 (ii) the agency, if the agency:
3895 (A) is reckless or negligent in its supervision of the individual; or
3896 (B) knowingly participates in the act or failure to act that is the ground for suspending,
3897 revoking, or limiting the license; or
3898 (iii) (A) the individual; and
3899 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
3900 (6) A licensee under this chapter is subject to the penalties for acting as a licensee
3901 without a license if:
3902 (a) the licensee's license is:
3903 (i) revoked;
3904 (ii) suspended;
3905 (iii) limited;
3906 (iv) surrendered in lieu of administrative action;
3907 (v) lapsed; or
3908 (vi) voluntarily surrendered; and
3909 (b) the licensee:
3910 (i) continues to act as a licensee; or
3911 (ii) violates the terms of the license limitation.
3912 (7) A licensee under this chapter shall immediately report to the commissioner:
3913 (a) a revocation, suspension, or limitation of the person's license in another state, the
3914 District of Columbia, or a territory of the United States;
3915 (b) the imposition of a disciplinary sanction imposed on that person by another state,
3916 the District of Columbia, or a territory of the United States; or
3917 (c) a judgment or injunction entered against that person on the basis of conduct
3918 involving:
3919 (i) fraud;
3920 (ii) deceit;
3921 (iii) misrepresentation; or

3922 (iv) a violation of an insurance law or rule.

3923 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
3924 license in lieu of administrative action may specify a time, not to exceed five years, within
3925 which the former licensee may not apply for a new license.

3926 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the
3927 former licensee may not apply for a new license for five years from the day on which the order
3928 or agreement is made without the express approval by the commissioner.

3929 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
3930 a license issued under this part if so ordered by a court.

3931 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
3932 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3933 Section 27. Section **31A-27a-104** is amended to read:

3934 **31A-27a-104. Persons covered.**

3935 (1) This chapter applies to:

3936 (a) an insurer who:

3937 (i) is doing, or has done, an insurance business in this state; and

3938 (ii) against whom a claim arising from that business may exist;

3939 (b) a person subject to examination by the commissioner;

3940 (c) an insurer who purports to do an insurance business in this state;

3941 (d) an insurer who has an insured who is resident in this state; and

3942 (e) in addition to Subsections (1)(a) through (d), a person doing business as follows:

3943 (i) under Chapter 6a, Service Contracts;

3944 (ii) under Chapter 7, Nonprofit Health Service Insurance Corporations;

3945 (iii) under Chapter 8a, Health Discount Program Consumer Protection Act;

3946 (iv) under Chapter 9, Insurance Fraternals;

3947 (v) under Chapter 11, Motor Clubs;

3948 (vi) under Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention
3949 Groups;

3950 (vii) as a bail bond surety company under Chapter 35, Bail Bond Act;
3951 (viii) under Chapter 37, Captive Insurance Companies Act;
3952 (ix) a title insurance company;
3953 (x) a prepaid health care delivery plan; and
3954 (xi) a person not described in Subsections (1)(e)(i) through (x) that is organized or
3955 doing insurance business, or in the process of organizing with the intent to do insurance
3956 business in this state.
3957 (2) Notwithstanding Sections 31A-1-301 and 31A-27a-102, this chapter does not apply
3958 to a person licensed by the insurance commissioner as one or more of the following in this state
3959 unless the person engages in the business of insurance as an insurer, is an affiliate as defined in
3960 Subsection 31A-1-301(5), or is a person under the control of an affiliate:
3961 (a) an insurance agency;
3962 (b) an insurance producer;
3963 (c) a limited line producer;
3964 (d) an insurance consultant;
3965 (e) a managing general agent;
3966 (f) reinsurance intermediary;
3967 (g) an individual title insurance producer or agency title insurance producer;
3968 (h) a third party administrator;
3969 (i) an insurance adjustor;
3970 (j) a life settlement provider; or
3971 (k) a life settlement producer.
3972 Section 28. Section **31A-27a-111** is amended to read:
3973 **31A-27a-111. Actions by and against the receiver.**
3974 (1) (a) An allegation by the receiver of improper or fraudulent conduct against a person
3975 may not be the basis of a defense to the enforcement of a contractual obligation owed to the
3976 insurer by a third party.
3977 (b) Notwithstanding Subsection (1)(a), a third party described in this Subsection (1) is

3978 not barred by this section from seeking to establish independently as a defense that the conduct
3979 is materially and substantially related to the contractual obligation for which enforcement is
3980 sought.
3981 (2) (a) Subject to Subsection (2)(b), a prior wrongful or negligent action of any present
3982 or former receiver, receiver's assistant, receiver's contractor, officer, manager, director, trustee,
3983 owner, employee, or agent of the insurer may not be asserted as a defense to a claim by the
3984 receiver:
3985 (i) under a theory of:
3986 (A) estoppel;
3987 (B) comparative fault;
3988 (C) intervening cause;
3989 (D) proximate cause;
3990 (E) reliance; or
3991 (F) mitigation of damages; or
3992 (ii) otherwise.
3993 (b) Notwithstanding Subsection (2)(a):
3994 (i) the affirmative defense of fraud in the inducement may be asserted against the
3995 receiver in a claim based on a contract; and
3996 (ii) a principal under a surety bond or a surety undertaking is entitled to credit against
3997 any reimbursement obligation to the receiver for the value of any property pledged to secure the
3998 reimbursement obligation to the extent that:
3999 (A) the receiver has possession or control of the property; or
4000 (B) the insurer or its agents misappropriated, including commingling, the property.
4001 (c) Evidence of fraud in the inducement is admissible only if it is contained in the
4002 records of the insurer.
4003 (3) Action or inaction by an insurance regulatory authority may not be asserted as a
4004 defense to a claim by the receiver.
4005 (4) (a) Subject to Subsection (4)(b), a judgment or order entered against an insured or

4006 the insurer in contravention of a stay or injunction under this chapter, or at any time by default
4007 or collusion, may not be considered as evidence of liability or of the quantum of damages in
4008 adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.
4009 (b) Subsection (4)(a) does not apply to an affected guaranty association's claim for
4010 amounts paid on a settlement or judgment in pursuit of the affected guaranty association's
4011 statutory obligations.
4012 (5) (a) Subject to Subsection (5)(b), the following do not affect the amount that a
4013 receiver may recover from a third party, regardless of any provision in an agreement to the
4014 contrary:
4015 (i) the insurer's insolvency; or
4016 (ii) the insurer's or receiver's failure to pay all or a portion of an amount or a claim to
4017 the third party.
4018 (b) If an agreement between the insurer and a third party requires a payment by the
4019 insurer before the insurer may recover from the third party, the amount the receiver may
4020 recover from the third party under Subsection (5)(a) is limited to an amount equal to the greater
4021 of:
4022 (i) the amount paid by the insurer or by another person on behalf of the insurer to the
4023 third party; or
4024 (ii) the amount allowed as a claim for payment under:
4025 (A) an approved report described in Section 31A-27a-608;
4026 (B) an order of the receivership court; or
4027 (C) a plan of rehabilitation.
4028 (6) The receiver may not be considered a governmental entity for the purposes of any
4029 state law awarding fees to a litigant who prevails against a governmental entity.
4030 Section 29. Section **31A-30-103** is amended to read:
4031 **31A-30-103. Definitions.**
4032 As used in this chapter:
4033 (1) "Actuarial certification" means a written statement by a member of the American

4034 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
4035 is in compliance with this chapter, based upon the examination of the covered carrier, including
4036 review of the appropriate records and of the actuarial assumptions and methods used by the
4037 covered carrier in establishing premium rates for applicable health benefit plans.
4038 (2) "Affiliate" or "affiliated" means a person who directly or indirectly through one or
4039 more intermediaries, controls or is controlled by, or is under common control with, a specified
4040 person.
4041 (3) "Base premium rate" means, for each class of business as to a rating period, the
4042 lowest premium rate charged or that could have been charged under a rating system for that
4043 class of business by the covered carrier to covered insureds with similar case characteristics for
4044 health benefit plans with the same or similar coverage.
4045 (4) (a) "Bona fide employer association" means an association of employers:
4046 (i) that meets the requirements of [~~Subsection 31A-22-701(2)(b)~~] Section 31A-22-505;
4047 (ii) in which the employers of the association, either directly or indirectly, exercise
4048 control over the plan;
4049 (iii) that is organized:
4050 (A) based on a commonality of interest between the employers and their employees
4051 that participate in the plan by some common economic or representation interest or genuine
4052 organizational relationship unrelated to the provision of benefits; and
4053 (B) to act in the best interests of its employers to provide benefits for the employer's
4054 employees and their spouses and dependents, and other benefits relating to employment; and
4055 (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.
4056 (b) The commissioner shall consider the following with regard to determining whether
4057 an association of employers is a bona fide employer association under Subsection (4)(a):
4058 (i) how association members are solicited;
4059 (ii) who participates in the association;
4060 (iii) the process by which the association was formed;
4061 (iv) the purposes for which the association was formed, and what, if any, were the

4062 pre-existing relationships of its members;
4063 (v) the powers, rights and privileges of employer members; and
4064 (vi) who actually controls and directs the activities and operations of the benefit
4065 programs.
4066 (5) "Carrier" means a person that provides health insurance in this state including:
4067 (a) an insurance company;
4068 (b) a prepaid hospital or medical care plan;
4069 (c) a health maintenance organization;
4070 (d) a multiple employer welfare arrangement; and
4071 (e) another person providing a health insurance plan under this title.
4072 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
4073 demographic or other objective characteristics of a covered insured that are considered by the
4074 carrier in determining premium rates for the covered insured.
4075 (b) "Case characteristics" do not include:
4076 (i) duration of coverage since the policy was issued;
4077 (ii) claim experience; and
4078 (iii) health status.
4079 (7) "Class of business" means all or a separate grouping of covered insureds that is
4080 permitted by the commissioner in accordance with Section 31A-30-105.
4081 (8) "Covered carrier" means an individual carrier or small employer carrier subject to
4082 this chapter.
4083 (9) "Covered individual" means an individual who is covered under a health benefit
4084 plan subject to this chapter.
4085 (10) "Covered insureds" means small employers and individuals who are issued a
4086 health benefit plan that is subject to this chapter.
4087 (11) "Dependent" means an individual to the extent that the individual is defined to be
4088 a dependent by:
4089 (a) the health benefit plan covering the covered individual; and

4090 (b) Chapter 22, Part 6, Accident and Health Insurance.
4091 (12) "Established geographic service area" means a geographical area approved by the
4092 commissioner within which the carrier is authorized to provide coverage.
4093 (13) "Index rate" means, for each class of business as to a rating period for covered
4094 insureds with similar case characteristics, the arithmetic average of the applicable base
4095 premium rate and the corresponding highest premium rate.
4096 (14) "Individual carrier" means a carrier that provides coverage on an individual basis
4097 through a health benefit plan regardless of whether:
4098 (a) coverage is offered through:
4099 (i) an association;
4100 (ii) a trust;
4101 (iii) a discretionary group; or
4102 (iv) other similar groups; or
4103 (b) the policy or contract is situated out-of-state.
4104 (15) "Individual conversion policy" means a conversion policy issued to:
4105 (a) an individual; or
4106 (b) an individual with a family.
4107 (16) "New business premium rate" means, for each class of business as to a rating
4108 period, the lowest premium rate charged or offered, or that could have been charged or offered,
4109 by the carrier to covered insureds with similar case characteristics for newly issued health
4110 benefit plans with the same or similar coverage.
4111 (17) "Premium" means money paid by covered insureds and covered individuals as a
4112 condition of receiving coverage from a covered carrier, including fees or other contributions
4113 associated with the health benefit plan.
4114 (18) (a) "Rating period" means the calendar period for which premium rates
4115 established by a covered carrier are assumed to be in effect, as determined by the carrier.
4116 (b) A covered carrier may not have:
4117 (i) more than one rating period in any calendar month; and

4118 (ii) no more than 12 rating periods in any calendar year.
4119 (19) "Small employer carrier" means a carrier that provides health benefit plans
4120 covering eligible employees of one or more small employers in this state, regardless of
4121 whether:
4122 (a) coverage is offered through:
4123 (i) an association;
4124 (ii) a trust;
4125 (iii) a discretionary group; or
4126 (iv) other similar grouping; or
4127 (b) the policy or contract is situated out-of-state.
4128 Section 30. Section **31A-35-404** is amended to read:
4129 **31A-35-404. Minimum financial requirements for bail bond agency license.**
4130 (1) (a) A bail bond agency that pledges the assets of a letter of credit from a Utah
4131 depository institution in connection with a judicial proceeding shall maintain an irrevocable
4132 letter of credit with a minimum face value of $300,000 assigned to the state from a Utah
4133 depository institution.
4134 (b) Notwithstanding Subsection (1)(a), a bail bond agency described in Subsection
4135 (1)(a) that is licensed under this chapter on or before December 31, 1999, shall maintain an
4136 irrevocable letter of credit with a minimum face value of $250,000 assigned to the state from a
4137 Utah depository institution.
4138 (2) (a) A bail bond agency that pledges personal or real property, or both, as security
4139 for a bail bond in connection with a judicial proceeding shall maintain a verified financial
4140 statement for the [~~current~~] bail bond agency's immediately preceding fiscal year:
4141 (i) reviewed by a certified public accountant; and
4142 (ii) showing a minimum net worth of:
4143 (A) $300,000, at least $100,000 of which is in liquid assets; or
4144 (B) if the bail bond agency is licensed under this chapter on or before December 31,
4145 1999, $250,000, at least $50,000 of which is in liquid assets.

4146 (b) For purposes of this Subsection (2), only real or personal property located in Utah
4147 may be included in the net worth of the bail bond agency.
4148 (3) A bail bond agency shall maintain a qualifying power of attorney issued by a surety
4149 insurer if:
4150 (a) the bail bond agency is the agent of the surety insurer; and
4151 (b) the surety insurer:
4152 (i) sells bail bonds;
4153 (ii) is in good standing in its state of domicile; and
4154 (iii) is granted a certificate to write bail bonds in Utah.
4155 (4) The commissioner may revoke the license of a bail bond agency that fails to
4156 maintain the minimum financial requirements required under this section.
4157 (5) The commissioner may set by rule the limits on the aggregate amounts of bail
4158 bonds issued by a bail bond agency.
4159 Section 31. Section **31A-48-102** is amended to read:
4160 **31A-48-102. Definitions.**
4161 As used in this chapter:
4162 (1) (a) "Drug" means [~~a prescription drug, as defined in Section 58-17b-102.~~] a
4163 substance that is:
4164 (i) (A) intended for use in the diagnosis, cure, mitigation, treatment, or prevention of
4165 disease in humans; and
4166 (B) recognized in or in a supplement to the official United States Pharmacopoeia, the
4167 Homeopathic Pharmacopoeia of the United States, or the official National Formulary;
4168 (ii) required by an applicable federal or state law or rule to be dispensed by prescription
4169 only;
4170 (iii) restricted to administration by practitioners only;
4171 (iv) a substance other than food intended to affect the structure or a function of the
4172 human body; or
4173 (v) intended for use as a component of a substance described in Subsection (1)(a)(i),

4174 (ii), (iii), or (iv).

4175 (b) "Drug" does not include a dietary supplement.

4176 (2) "Insurer" means the same as that term is defined in Section 31A-22-634.

4177 (3) "Manufacturer" means a person that is engaged in the manufacturing of a drug that

4178 is available for purchase by residents of the state.

4179 (4) "Rebate" means the same as that term is defined in Section 31A-46-102.

4180 (5) "Wholesale acquisition cost" means the same as that term is defined in 42 U.S.C.

4181 Sec. 1395w-3a.

4182 Section 32. Section **31A-48-103** is amended to read:

4183 **31A-48-103. Manufacturer reports -- Insurer report -- Publication by**

4184 **department.**

4185 (1) (a) A manufacturer of a drug shall, beginning January 1, 2022, report to the

4186 department the information described in Subsection (1)(b) no more than 30 days after the day

4187 on which an increase to the wholesale acquisition cost of the drug results in an increase to the

4188 wholesale acquisition cost of the drug of:

4189 (i) greater than 16% over the preceding two calendar years; or

4190 (ii) greater than 10% over the preceding calendar year.

4191 (b) The manufacturer shall report:

4192 (i) (A) the name of the drug;

4193 (B) the dosage form of the drug; and

4194 (C) the strength of the drug;

4195 (ii) whether the drug is a brand name drug or a generic drug;

4196 (iii) the effective date of the increase in the wholesale acquisition cost of the drug;

4197 (iv) a written description, suitable for public release, of the factors that led to the

4198 increase in the wholesale acquisition cost of the drug and the significance of each factor;

4199 (v) the manufacturer's aggregate company-wide research and development costs for the

4200 most recent year for which final audit data is available;

4201 (vi) the name of each of the manufacturer's drugs approved by the United States Food

4202 and Drug Administration during the preceding three calendar years; and
4203 (vii) the names of drugs manufactured by the manufacturer that lost patent exclusivity
4204 in the United States during the preceding three calendar years.
4205 (c) Subsection (1)(a) applies only to a drug with a wholesale acquisition cost of at least
4206 $100 for a 30-day supply before the effective date of the increase in the wholesale acquisition
4207 cost of the drug.
4208 (d) [~~A manufacturer's obligations under this Subsection (1) are fully satisfied by~~
4209 ~~submission~~] The quality and types of information and data that a manufacturer submits under
4210 this Subsection (1) shall be consistent with the quality and types of information and data that
4211 the manufacturer includes in the manufacturer's annual consolidated report on Securities and
4212 Exchange Commission Form 10-K or any other public disclosure.
4213 (e) The department shall consult with representatives of manufacturers to establish a
4214 single, standardized format for reporting information under this section that minimizes the
4215 administrative burden of reporting for manufacturers and the state.
4216 [~~(f) Information provided to the department under Subsection (1)(b) may not be~~
4217 ~~released in a manner that:~~]
4218 [~~(i) would allow for the identification of an individual drug, therapeutic class of drugs,~~
4219 ~~or manufacturer; or~~]
4220 [~~(ii) is likely to compromise the financial, competitive, or proprietary nature of the~~
4221 ~~information.~~]
4222 (2) On or before August 1, 2021, and on or before August 1 of each year thereafter, an
4223 insurer shall report to the department in aggregate the following information for the preceding
4224 calendar year for health benefit plans offered by the insurer:
4225 (a) for the 25 drugs for which spending by the insurer was the greatest, after adjusting
4226 for rebates:
4227 (i) the name of the drug;
4228 (ii) the dosage form of the drug; and
4229 (iii) the strength of the drug;

4230 (b) the percentage increase over the previous year in net spending for all drugs, after
4231 adjusting for rebates; [~~and~~]
4232 (c) the percentage of the increase in premiums over the previous year attributable to all
4233 drugs; and
4234 (d) the percentage of the increase in premiums over the previous year attributable to
4235 specialty drugs.
4236 (3) The department shall publish on the department's website:
4237 (a) no later than 60 days after receiving the information, information reported to the
4238 department under Subsection (1); and
4239 (b) no later than December 1 of each year, information reported to the department
4240 under Subsection (2).
4241 (4) (a) The department may not publish information under [~~Subsection (3)(b)~~] this
4242 section in a manner that:
4243 (i) allows the identity of an insurer to be determined[~~.~~];
4244 (ii) allows for the identification of an individual drug, a therapeutic class of drugs, or a
4245 manufacturer; or
4246 (iii) is likely to compromise the financial, competitive, or proprietary nature of the
4247 information.
4248 (b) The commissioner shall classify each record submitted under this section as a
4249 protected record under Title 63G, Chapter 2, Government Records Access and Management
4250 Act.
4251 (5) The department shall make rules, as necessary, in accordance with Title 63G,
4252 Chapter 3, Utah Administrative Rulemaking Act, to promote comparability of information
4253 reported to the department under this chapter.
4254 Section 33. Section **58-13-2.5** is amended to read:
4255 **58-13-2.5. Standard of proof for emergency care when immunity does not apply.**
4256 (1) A person who is a health care provider as defined in Section 78B-3-403 who
4257 provides emergency care in good faith, but is not immune from suit because of an expectation

4258 of payment, a legal duty to respond, or other reason under Section 58-13-2, may only be liable
4259 for civil damages if fault, as defined in Section 78B-5-817, is established by clear and
4260 convincing evidence.
4261 (2) For purposes of Subsection (1), "emergency care" means the treatment of an
4262 emergency medical condition, as defined in Section [~~31A-22-627~~] 31A-1-301, from the time
4263 that the person presents at the emergency department of a hospital and including any
4264 subsequent transfer to another hospital, until the condition has been stabilized and the patient is
4265 either discharged from the emergency department or admitted to another department of the
4266 hospital.
4267 (3) This section does not apply to emergency care provided by a physician if:
4268 (a) the physician has a previously established physician/patient relationship with the
4269 patient outside of the emergency room;
4270 (b) the patient has been seen in the last three months by the physician for the same
4271 condition for which emergency care is sought; and
4272 (c) the physician can access and consult the patient's relevant medical care records
4273 while the physician is making decisions about and providing the emergency care.
4274 (4) (a) Nothing in this section may be construed as:
4275 (i) altering the applicable standard of care for determining fault; or
4276 (ii) applying the standard of proof of clear and convincing evidence to care outside of
4277 emergency care and the mandatory legal duty to treat.
4278 (b) This section applies to emergency care given after June 1, 2009.
4279 (5) This section sunsets in accordance with Section 63I-1-258.
4280 Section 34. Section **63G-2-305** is amended to read:
4281 **63G-2-305. Protected records.**
4282 The following records are protected if properly classified by a governmental entity:
4283 (1) trade secrets as defined in Section 13-24-2 if the person submitting the trade secret
4284 has provided the governmental entity with the information specified in Section 63G-2-309;
4285 (2) commercial information or nonindividual financial information obtained from a

4286 person if:

4287 (a) disclosure of the information could reasonably be expected to result in unfair

4288 competitive injury to the person submitting the information or would impair the ability of the

4289 governmental entity to obtain necessary information in the future;

4290 (b) the person submitting the information has a greater interest in prohibiting access

4291 than the public in obtaining access; and

4292 (c) the person submitting the information has provided the governmental entity with

4293 the information specified in Section 63G-2-309;

4294 (3) commercial or financial information acquired or prepared by a governmental entity

4295 to the extent that disclosure would lead to financial speculations in currencies, securities, or

4296 commodities that will interfere with a planned transaction by the governmental entity or cause

4297 substantial financial injury to the governmental entity or state economy;

4298 (4) records, the disclosure of which could cause commercial injury to, or confer a

4299 competitive advantage upon a potential or actual competitor of, a commercial project entity as

4300 defined in Subsection 11-13-103(4);

4301 (5) test questions and answers to be used in future license, certification, registration,

4302 employment, or academic examinations;

4303 (6) records, the disclosure of which would impair governmental procurement

4304 proceedings or give an unfair advantage to any person proposing to enter into a contract or

4305 agreement with a governmental entity, except, subject to Subsections (1) and (2), that this

4306 Subsection (6) does not restrict the right of a person to have access to, after the contract or

4307 grant has been awarded and signed by all parties:

4308 (a) a bid, proposal, application, or other information submitted to or by a governmental

4309 entity in response to:

4310 (i) an invitation for bids;

4311 (ii) a request for proposals;

4312 (iii) a request for quotes;

4313 (iv) a grant; or

4314 (v) other similar document; or
4315 (b) an unsolicited proposal, as defined in Section 63G-6a-712;
4316 (7) information submitted to or by a governmental entity in response to a request for
4317 information, except, subject to Subsections (1) and (2), that this Subsection (7) does not restrict
4318 the right of a person to have access to the information, after:
4319 (a) a contract directly relating to the subject of the request for information has been
4320 awarded and signed by all parties; or
4321 (b) (i) a final determination is made not to enter into a contract that relates to the
4322 subject of the request for information; and
4323 (ii) at least two years have passed after the day on which the request for information is
4324 issued;
4325 (8) records that would identify real property or the appraisal or estimated value of real
4326 or personal property, including intellectual property, under consideration for public acquisition
4327 before any rights to the property are acquired unless:
4328 (a) public interest in obtaining access to the information is greater than or equal to the
4329 governmental entity's need to acquire the property on the best terms possible;
4330 (b) the information has already been disclosed to persons not employed by or under a
4331 duty of confidentiality to the entity;
4332 (c) in the case of records that would identify property, potential sellers of the described
4333 property have already learned of the governmental entity's plans to acquire the property;
4334 (d) in the case of records that would identify the appraisal or estimated value of
4335 property, the potential sellers have already learned of the governmental entity's estimated value
4336 of the property; or
4337 (e) the property under consideration for public acquisition is a single family residence
4338 and the governmental entity seeking to acquire the property has initiated negotiations to acquire
4339 the property as required under Section 78B-6-505;
4340 (9) records prepared in contemplation of sale, exchange, lease, rental, or other
4341 compensated transaction of real or personal property including intellectual property, which, if

4342 disclosed prior to completion of the transaction, would reveal the appraisal or estimated value
4343 of the subject property, unless:
4344 (a) the public interest in access is greater than or equal to the interests in restricting
4345 access, including the governmental entity's interest in maximizing the financial benefit of the
4346 transaction; or
4347 (b) when prepared by or on behalf of a governmental entity, appraisals or estimates of
4348 the value of the subject property have already been disclosed to persons not employed by or
4349 under a duty of confidentiality to the entity;
4350 (10) records created or maintained for civil, criminal, or administrative enforcement
4351 purposes or audit purposes, or for discipline, licensing, certification, or registration purposes, if
4352 release of the records:
4353 (a) reasonably could be expected to interfere with investigations undertaken for
4354 enforcement, discipline, licensing, certification, or registration purposes;
4355 (b) reasonably could be expected to interfere with audits, disciplinary, or enforcement
4356 proceedings;
4357 (c) would create a danger of depriving a person of a right to a fair trial or impartial
4358 hearing;
4359 (d) reasonably could be expected to disclose the identity of a source who is not
4360 generally known outside of government and, in the case of a record compiled in the course of
4361 an investigation, disclose information furnished by a source not generally known outside of
4362 government if disclosure would compromise the source; or
4363 (e) reasonably could be expected to disclose investigative or audit techniques,
4364 procedures, policies, or orders not generally known outside of government if disclosure would
4365 interfere with enforcement or audit efforts;
4366 (11) records the disclosure of which would jeopardize the life or safety of an
4367 individual;
4368 (12) records the disclosure of which would jeopardize the security of governmental
4369 property, governmental programs, or governmental recordkeeping systems from damage, theft,

4370 or other appropriation or use contrary to law or public policy;
4371 (13) records that, if disclosed, would jeopardize the security or safety of a correctional
4372 facility, or records relating to incarceration, treatment, probation, or parole, that would interfere
4373 with the control and supervision of an offender's incarceration, treatment, probation, or parole;
4374 (14) records that, if disclosed, would reveal recommendations made to the Board of
4375 Pardons and Parole by an employee of or contractor for the Department of Corrections, the
4376 Board of Pardons and Parole, or the Department of Human Services that are based on the
4377 employee's or contractor's supervision, diagnosis, or treatment of any person within the board's
4378 jurisdiction;
4379 (15) records and audit workpapers that identify audit, collection, and operational
4380 procedures and methods used by the State Tax Commission, if disclosure would interfere with
4381 audits or collections;
4382 (16) records of a governmental audit agency relating to an ongoing or planned audit
4383 until the final audit is released;
4384 (17) records that are subject to the attorney client privilege;
4385 (18) records prepared for or by an attorney, consultant, surety, indemnitor, insurer,
4386 employee, or agent of a governmental entity for, or in anticipation of, litigation or a judicial,
4387 quasi-judicial, or administrative proceeding;
4388 (19) (a) (i) personal files of a state legislator, including personal correspondence to or
4389 from a member of the Legislature; and
4390 (ii) notwithstanding Subsection (19)(a)(i), correspondence that gives notice of
4391 legislative action or policy may not be classified as protected under this section; and
4392 (b) (i) an internal communication that is part of the deliberative process in connection
4393 with the preparation of legislation between:
4394 (A) members of a legislative body;
4395 (B) a member of a legislative body and a member of the legislative body's staff; or
4396 (C) members of a legislative body's staff; and
4397 (ii) notwithstanding Subsection (19)(b)(i), a communication that gives notice of

4398 legislative action or policy may not be classified as protected under this section;
4399 (20) (a) records in the custody or control of the Office of Legislative Research and
4400 General Counsel, that, if disclosed, would reveal a particular legislator's contemplated
4401 legislation or contemplated course of action before the legislator has elected to support the
4402 legislation or course of action, or made the legislation or course of action public; and
4403 (b) notwithstanding Subsection (20)(a), the form to request legislation submitted to the
4404 Office of Legislative Research and General Counsel is a public document unless a legislator
4405 asks that the records requesting the legislation be maintained as protected records until such
4406 time as the legislator elects to make the legislation or course of action public;
4407 (21) research requests from legislators to the Office of Legislative Research and
4408 General Counsel or the Office of the Legislative Fiscal Analyst and research findings prepared
4409 in response to these requests;
4410 (22) drafts, unless otherwise classified as public;
4411 (23) records concerning a governmental entity's strategy about:
4412 (a) collective bargaining; or
4413 (b) imminent or pending litigation;
4414 (24) records of investigations of loss occurrences and analyses of loss occurrences that
4415 may be covered by the Risk Management Fund, the Employers' Reinsurance Fund, the
4416 Uninsured Employers' Fund, or similar divisions in other governmental entities;
4417 (25) records, other than personnel evaluations, that contain a personal recommendation
4418 concerning an individual if disclosure would constitute a clearly unwarranted invasion of
4419 personal privacy, or disclosure is not in the public interest;
4420 (26) records that reveal the location of historic, prehistoric, paleontological, or
4421 biological resources that if known would jeopardize the security of those resources or of
4422 valuable historic, scientific, educational, or cultural information;
4423 (27) records of independent state agencies if the disclosure of the records would
4424 conflict with the fiduciary obligations of the agency;
4425 (28) records of an institution within the state system of higher education defined in

4426 Section 53B-1-102 regarding tenure evaluations, appointments, applications for admissions,
4427 retention decisions, and promotions, which could be properly discussed in a meeting closed in
4428 accordance with Title 52, Chapter 4, Open and Public Meetings Act, provided that records of
4429 the final decisions about tenure, appointments, retention, promotions, or those students
4430 admitted, may not be classified as protected under this section;
4431 (29) records of the governor's office, including budget recommendations, legislative
4432 proposals, and policy statements, that if disclosed would reveal the governor's contemplated
4433 policies or contemplated courses of action before the governor has implemented or rejected
4434 those policies or courses of action or made them public;
4435 (30) records of the Office of the Legislative Fiscal Analyst relating to budget analysis,
4436 revenue estimates, and fiscal notes of proposed legislation before issuance of the final
4437 recommendations in these areas;
4438 (31) records provided by the United States or by a government entity outside the state
4439 that are given to the governmental entity with a requirement that they be managed as protected
4440 records if the providing entity certifies that the record would not be subject to public disclosure
4441 if retained by it;
4442 (32) transcripts, minutes, recordings, or reports of the closed portion of a meeting of a
4443 public body except as provided in Section 52-4-206;
4444 (33) records that would reveal the contents of settlement negotiations but not including
4445 final settlements or empirical data to the extent that they are not otherwise exempt from
4446 disclosure;
4447 (34) memoranda prepared by staff and used in the decision-making process by an
4448 administrative law judge, a member of the Board of Pardons and Parole, or a member of any
4449 other body charged by law with performing a quasi-judicial function;
4450 (35) records that would reveal negotiations regarding assistance or incentives offered
4451 by or requested from a governmental entity for the purpose of encouraging a person to expand
4452 or locate a business in Utah, but only if disclosure would result in actual economic harm to the
4453 person or place the governmental entity at a competitive disadvantage, but this section may not

4454 be used to restrict access to a record evidencing a final contract;
4455 (36) materials to which access must be limited for purposes of securing or maintaining
4456 the governmental entity's proprietary protection of intellectual property rights including patents,
4457 copyrights, and trade secrets;
4458 (37) the name of a donor or a prospective donor to a governmental entity, including an
4459 institution within the state system of higher education defined in Section 53B-1-102, and other
4460 information concerning the donation that could reasonably be expected to reveal the identity of
4461 the donor, provided that:
4462 (a) the donor requests anonymity in writing;
4463 (b) any terms, conditions, restrictions, or privileges relating to the donation may not be
4464 classified protected by the governmental entity under this Subsection (37); and
4465 (c) except for an institution within the state system of higher education defined in
4466 Section 53B-1-102, the governmental unit to which the donation is made is primarily engaged
4467 in educational, charitable, or artistic endeavors, and has no regulatory or legislative authority
4468 over the donor, a member of the donor's immediate family, or any entity owned or controlled
4469 by the donor or the donor's immediate family;
4470 (38) accident reports, except as provided in Sections 41-6a-404, 41-12a-202, and
4471 73-18-13;
4472 (39) a notification of workers' compensation insurance coverage described in Section
4473 34A-2-205;
4474 (40) (a) the following records of an institution within the state system of higher
4475 education defined in Section 53B-1-102, which have been developed, discovered, disclosed to,
4476 or received by or on behalf of faculty, staff, employees, or students of the institution:
4477 (i) unpublished lecture notes;
4478 (ii) unpublished notes, data, and information:
4479 (A) relating to research; and
4480 (B) of:
4481 (I) the institution within the state system of higher education defined in Section

4482 53B-1-102; or
4483 (II) a sponsor of sponsored research;
4484 (iii) unpublished manuscripts;
4485 (iv) creative works in process;
4486 (v) scholarly correspondence; and
4487 (vi) confidential information contained in research proposals;
4488 (b) Subsection (40)(a) may not be construed to prohibit disclosure of public
4489 information required pursuant to Subsection 53B-16-302(2)(a) or (b); and
4490 (c) Subsection (40)(a) may not be construed to affect the ownership of a record;
4491 (41) (a) records in the custody or control of the Office of the Legislative Auditor
4492 General that would reveal the name of a particular legislator who requests a legislative audit
4493 prior to the date that audit is completed and made public; and
4494 (b) notwithstanding Subsection (41)(a), a request for a legislative audit submitted to the
4495 Office of the Legislative Auditor General is a public document unless the legislator asks that
4496 the records in the custody or control of the Office of the Legislative Auditor General that would
4497 reveal the name of a particular legislator who requests a legislative audit be maintained as
4498 protected records until the audit is completed and made public;
4499 (42) records that provide detail as to the location of an explosive, including a map or
4500 other document that indicates the location of:
4501 (a) a production facility; or
4502 (b) a magazine;
4503 (43) information:
4504 (a) contained in the statewide database of the Division of Aging and Adult Services
4505 created by Section 62A-3-311.1; or
4506 (b) received or maintained in relation to the Identity Theft Reporting Information
4507 System (IRIS) established under Section 67-5-22;
4508 (44) information contained in the Licensing Information System described in Title
4509 62A, Chapter 4a, Child and Family Services;

4510 (45) information regarding National Guard operations or activities in support of the
4511 National Guard's federal mission;
4512 (46) records provided by any pawn or secondhand business to a law enforcement
4513 agency or to the central database in compliance with Title 13, Chapter 32a, Pawnshop and
4514 Secondhand Merchandise Transaction Information Act;
4515 (47) information regarding food security, risk, and vulnerability assessments performed
4516 by the Department of Agriculture and Food;
4517 (48) except to the extent that the record is exempt from this chapter pursuant to Section
4518 63G-2-106, records related to an emergency plan or program, a copy of which is provided to or
4519 prepared or maintained by the Division of Emergency Management, and the disclosure of
4520 which would jeopardize:
4521 (a) the safety of the general public; or
4522 (b) the security of:
4523 (i) governmental property;
4524 (ii) governmental programs; or
4525 (iii) the property of a private person who provides the Division of Emergency
4526 Management information;
4527 (49) records of the Department of Agriculture and Food that provides for the
4528 identification, tracing, or control of livestock diseases, including any program established under
4529 Title 4, Chapter 24, Utah Livestock Brand and Anti-Theft Act, or Title 4, Chapter 31, Control
4530 of Animal Disease;
4531 (50) as provided in Section 26-39-501:
4532 (a) information or records held by the Department of Health related to a complaint
4533 regarding a child care program or residential child care which the department is unable to
4534 substantiate; and
4535 (b) information or records related to a complaint received by the Department of Health
4536 from an anonymous complainant regarding a child care program or residential child care;
4537 (51) unless otherwise classified as public under Section 63G-2-301 and except as

4538 provided under Section 41-1a-116, an individual's home address, home telephone number, or
4539 personal mobile phone number, if:
4540 (a) the individual is required to provide the information in order to comply with a law,
4541 ordinance, rule, or order of a government entity; and
4542 (b) the subject of the record has a reasonable expectation that this information will be
4543 kept confidential due to:
4544 (i) the nature of the law, ordinance, rule, or order; and
4545 (ii) the individual complying with the law, ordinance, rule, or order;
4546 (52) the portion of the following documents that contains a candidate's residential or
4547 mailing address, if the candidate provides to the filing officer another address or phone number
4548 where the candidate may be contacted:
4549 (a) a declaration of candidacy, a nomination petition, or a certificate of nomination,
4550 described in Section 20A-9-201, 20A-9-202, 20A-9-203, 20A-9-404, 20A-9-405, 20A-9-408,
4551 20A-9-408.5, 20A-9-502, or 20A-9-601;
4552 (b) an affidavit of impecuniosity, described in Section 20A-9-201; or
4553 (c) a notice of intent to gather signatures for candidacy, described in Section
4554 20A-9-408;
4555 (53) the name, home address, work addresses, and telephone numbers of an individual
4556 that is engaged in, or that provides goods or services for, medical or scientific research that is:
4557 (a) conducted within the state system of higher education, as defined in Section
4558 53B-1-102; and
4559 (b) conducted using animals;
4560 (54) in accordance with Section 78A-12-203, any record of the Judicial Performance
4561 Evaluation Commission concerning an individual commissioner's vote on whether or not to
4562 recommend that the voters retain a judge including information disclosed under Subsection
4563 78A-12-203(5)(e);
4564 (55) information collected and a report prepared by the Judicial Performance
4565 Evaluation Commission concerning a judge, unless Section 20A-7-702 or Title 78A, Chapter

4566 12, Judicial Performance Evaluation Commission Act, requires disclosure of, or makes public,
4567 the information or report;
4568 (56) records provided or received by the Public Lands Policy Coordinating Office in
4569 furtherance of any contract or other agreement made in accordance with Section 63L-11-202;
4570 (57) information requested by and provided to the 911 Division under Section
4571 63H-7a-302;
4572 (58) in accordance with Section 73-10-33:
4573 (a) a management plan for a water conveyance facility in the possession of the Division
4574 of Water Resources or the Board of Water Resources; or
4575 (b) an outline of an emergency response plan in possession of the state or a county or
4576 municipality;
4577 (59) the following records in the custody or control of the Office of Inspector General
4578 of Medicaid Services, created in Section 63A-13-201:
4579 (a) records that would disclose information relating to allegations of personal
4580 misconduct, gross mismanagement, or illegal activity of a person if the information or
4581 allegation cannot be corroborated by the Office of Inspector General of Medicaid Services
4582 through other documents or evidence, and the records relating to the allegation are not relied
4583 upon by the Office of Inspector General of Medicaid Services in preparing a final investigation
4584 report or final audit report;
4585 (b) records and audit workpapers to the extent they would disclose the identity of a
4586 person who, during the course of an investigation or audit, communicated the existence of any
4587 Medicaid fraud, waste, or abuse, or a violation or suspected violation of a law, rule, or
4588 regulation adopted under the laws of this state, a political subdivision of the state, or any
4589 recognized entity of the United States, if the information was disclosed on the condition that
4590 the identity of the person be protected;
4591 (c) before the time that an investigation or audit is completed and the final
4592 investigation or final audit report is released, records or drafts circulated to a person who is not
4593 an employee or head of a governmental entity for the person's response or information;

4594 (d) records that would disclose an outline or part of any investigation, audit survey
4595 plan, or audit program; or
4596 (e) requests for an investigation or audit, if disclosure would risk circumvention of an
4597 investigation or audit;
4598 (60) records that reveal methods used by the Office of Inspector General of Medicaid
4599 Services, the fraud unit, or the Department of Health, to discover Medicaid fraud, waste, or
4600 abuse;
4601 (61) information provided to the Department of Health or the Division of Occupational
4602 and Professional Licensing under Subsections 58-67-304(3) and (4) and Subsections
4603 58-68-304(3) and (4);
4604 (62) a record described in Section 63G-12-210;
4605 (63) captured plate data that is obtained through an automatic license plate reader
4606 system used by a governmental entity as authorized in Section 41-6a-2003;
4607 (64) any record in the custody of the Utah Office for Victims of Crime relating to a
4608 victim, including:
4609 (a) a victim's application or request for benefits;
4610 (b) a victim's receipt or denial of benefits; and
4611 (c) any administrative notes or records made or created for the purpose of, or used to,
4612 evaluate or communicate a victim's eligibility for or denial of benefits from the Crime Victim
4613 Reparations Fund;
4614 (65) an audio or video recording created by a body-worn camera, as that term is
4615 defined in Section 77-7a-103, that records sound or images inside a hospital or health care
4616 facility as those terms are defined in Section 78B-3-403, inside a clinic of a health care
4617 provider, as that term is defined in Section 78B-3-403, or inside a human service program as
4618 that term is defined in Section 62A-2-101, except for recordings that:
4619 (a) depict the commission of an alleged crime;
4620 (b) record any encounter between a law enforcement officer and a person that results in
4621 death or bodily injury, or includes an instance when an officer fires a weapon;

4622 (c) record any encounter that is the subject of a complaint or a legal proceeding against
4623 a law enforcement officer or law enforcement agency;
4624 (d) contain an officer involved critical incident as defined in Subsection
4625 76-2-408(1)(f); or
4626 (e) have been requested for reclassification as a public record by a subject or
4627 authorized agent of a subject featured in the recording;
4628 (66) a record pertaining to the search process for a president of an institution of higher
4629 education described in Section 53B-2-102, except for application materials for a publicly
4630 announced finalist;
4631 (67) an audio recording that is:
4632 (a) produced by an audio recording device that is used in conjunction with a device or
4633 piece of equipment designed or intended for resuscitating an individual or for treating an
4634 individual with a life-threatening condition;
4635 (b) produced during an emergency event when an individual employed to provide law
4636 enforcement, fire protection, paramedic, emergency medical, or other first responder service:
4637 (i) is responding to an individual needing resuscitation or with a life-threatening
4638 condition; and
4639 (ii) uses a device or piece of equipment designed or intended for resuscitating an
4640 individual or for treating an individual with a life-threatening condition; and
4641 (c) intended and used for purposes of training emergency responders how to improve
4642 their response to an emergency situation;
4643 (68) records submitted by or prepared in relation to an applicant seeking a
4644 recommendation by the Research and General Counsel Subcommittee, the Budget
4645 Subcommittee, or the Audit Subcommittee, established under Section 36-12-8, for an
4646 employment position with the Legislature;
4647 (69) work papers as defined in Section 31A-2-204;
4648 (70) a record made available to Adult Protective Services or a law enforcement agency
4649 under Section 61-1-206;

4650 (71) a record submitted to the Insurance Department in accordance with Section
4651 31A-37-201;
4652 (72) a record described in Section 31A-37-503;
4653 (73) any record created by the Division of Occupational and Professional Licensing as
4654 a result of Subsection 58-37f-304(5) or 58-37f-702(2)(a)(ii);
4655 (74) a record described in Section 72-16-306 that relates to the reporting of an injury
4656 involving an amusement ride;
4657 (75) except as provided in Subsection 63G-2-305.5(1), the signature of an individual
4658 on a political petition, or on a request to withdraw a signature from a political petition,
4659 including a petition or request described in the following titles:
4660 (a) Title 10, Utah Municipal Code;
4661 (b) Title 17, Counties;
4662 (c) Title 17B, Limited Purpose Local Government Entities - Local Districts;
4663 (d) Title 17D, Limited Purpose Local Government Entities - Other Entities; and
4664 (e) Title 20A, Election Code;
4665 (76) except as provided in Subsection 63G-2-305.5(2), the signature of an individual in
4666 a voter registration record;
4667 (77) except as provided in Subsection 63G-2-305.5(3), any signature, other than a
4668 signature described in Subsection (75) or (76), in the custody of the lieutenant governor or a
4669 local political subdivision collected or held under, or in relation to, Title 20A, Election Code;
4670 (78) a Form I-918 Supplement B certification as described in Title 77, Chapter 38, Part
4671 5, Victims Guidelines for Prosecutors Act;
4672 (79) a record submitted to the Insurance Department under [~~Subsection~~] Section
4673 31A-48-103[~~(1)(b)~~];
4674 (80) personal information, as defined in Section 63G-26-102, to the extent disclosure is
4675 prohibited under Section 63G-26-103;
4676 (81) (a) an image taken of an individual during the process of booking the individual
4677 into jail, unless:

4678 (i) the individual is convicted of a criminal offense based upon the conduct for which
4679 the individual was incarcerated at the time the image was taken;
4680 (ii) a law enforcement agency releases or disseminates the image after determining
4681 that:
4682 (A) the individual is a fugitive or an imminent threat to an individual or to public
4683 safety; and
4684 (B) releasing or disseminating the image will assist in apprehending the individual or
4685 reducing or eliminating the threat; or
4686 (iii) a judge orders the release or dissemination of the image based on a finding that the
4687 release or dissemination is in furtherance of a legitimate law enforcement interest[.];
4688 (82) a record:
4689 (a) concerning an interstate claim to the use of waters in the Colorado River system;
4690 (b) relating to a judicial proceeding, administrative proceeding, or negotiation with a
4691 representative from another state or the federal government as provided in Section
4692 63M-14-205; and
4693 (c) the disclosure of which would:
4694 (i) reveal a legal strategy relating to the state's claim to the use of the water in the
4695 Colorado River system;
4696 (ii) harm the ability of the Colorado River Authority of Utah or river commissioner to
4697 negotiate the best terms and conditions regarding the use of water in the Colorado River
4698 system; or
4699 (iii) give an advantage to another state or to the federal government in negotiations
4700 regarding the use of water in the Colorado River system; and
4701 (83) any part of an application described in Section 63N-16-201 that the Governor's
4702 Office of Economic Opportunity determines is nonpublic, confidential information that if
4703 disclosed would result in actual economic harm to the applicant, but this Subsection (83) may
4704 not be used to restrict access to a record evidencing a final contract or approval decision.
4705 Section 35. Section **76-6-521** is amended to read:

4706 **76-6-521. Fraudulent insurance act.**

4707 (1) A person commits a fraudulent insurance act if that person with intent to deceive or
4708 defraud:

4709 (a) presents or causes to be presented any oral or written statement or representation
4710 knowing that the statement or representation contains false or fraudulent information
4711 concerning any fact material to an application for the issuance or renewal of an insurance
4712 policy, certificate, or contract, as part of or in support of:

4713 (i) obtaining an insurance policy the insurer would otherwise not issue on the basis of
4714 underwriting criteria applicable to the person;

4715 (ii) a scheme or artifice to avoid paying the premium that an insurer charges on the
4716 basis of underwriting criteria applicable to the person; or

4717 (iii) a scheme or artifice to file an insurance claim for a loss that has already occurred;

4718 (b) presents, or causes to be presented, any oral or written statement or representation:

4719 (i) (A) as part of or in support of a claim for payment or other benefit pursuant to an
4720 insurance policy, certificate, or contract; or

4721 (B) in connection with any civil claim asserted for recovery of damages for personal or
4722 bodily injuries or property damage; and

4723 (ii) knowing that the statement or representation contains false, incomplete, or
4724 fraudulent information concerning any fact or thing material to the claim;

4725 (c) knowingly accepts a benefit from proceeds derived from a fraudulent insurance act;

4726 (d) intentionally, knowingly, or recklessly devises a scheme or artifice to obtain fees
4727 for professional services, or anything of value by means of false or fraudulent pretenses,
4728 representations, promises, or material omissions;

4729 (e) knowingly employs, uses, or acts as a runner, as defined in Section 31A-31-102, for
4730 the purpose of committing a fraudulent insurance act;

4731 (f) knowingly assists, abets, solicits, or conspires with another to commit a fraudulent
4732 insurance act;

4733 (g) knowingly supplies false or fraudulent material information in any document or

4734 statement required by the Department of Insurance; or

4735 (h) knowingly fails to forward a premium to an insurer in violation of Section

4736 31A-23a-411.1.

4737 (2) (a) A violation of Subsection (1)(a) (i) is a class A misdemeanor.

4738 (b) A violation of Subsections (1)(a)(ii) or (1)(b) through (1) (h) is punishable as in the

4739 manner prescribed by Section 76-10-1801 for communication fraud for property of like value.

4740 (c) A violation of Subsection (1)(a)(iii):

4741 (i) is a class A misdemeanor if the value of the loss is less than $1,500 or unable to be

4742 determined; or

4743 (ii) if the value of the loss is $1,500 or more, is punishable as in the manner prescribed

4744 by Section 76-10-1801 for communication fraud for property of like value.

4745 (3) A corporation or association is guilty of the offense of insurance fraud under the

4746 same conditions as those set forth in Section 76-2-204.

4747 (4) The determination of the degree of any offense under Subsections (1)(a)(ii) and

4748 (1)(b) through (1)(h) shall be measured by the total value of all property, money, or other things

4749 obtained or sought to be obtained by the fraudulent insurance act or acts described in

4750 Subsections (1)(a)(ii) and (1)(b) through (1)(h).

4751 Section 36. **Repealer.**

4752 This bill repeals:

4753 Section **31A-17-519, Small company exemption.**