

**Representative James A. Dunnigan** proposes the following substitute bill:

**INSURANCE RELATED MODIFICATIONS**

2017 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: James A. Dunnigan**

Senate Sponsor: Curtis S. Bramble

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**LONG TITLE**

**General Description:**

This bill modifies provisions related to insurance.

**Highlighted Provisions:**

This bill:

- ▶ modifies enforcement penalties and procedures;
- ▶ replaces the term "health benefit product" with "health benefit plan";
- ▶ clarifies that rules are made under Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
- ▶ addresses taxation;
- ▶ requires licensees who are foreign insurers to provide contact information and maintain certain records;
- ▶ modifies due date of insurer holding company filing;
- ▶ enacts the Risk Management and Own Risk and Solvency Assessment Act,

including:

- providing the scope of the chapter;
- defining terms;
- requiring a risk management framework;
- requiring an own risk and solvency assessment;



- 26           • providing for a summary report and its contents;
- 27           • providing for exemptions;
- 28           • addressing confidentiality;
- 29           • establishing sanctions; and
- 30           • providing a severability clause;
- 31       ▶ addresses risk based capital provisions;
- 32       ▶ addresses association groups;
- 33       ▶ modifies accident and health insurance standards provisions;
- 34       ▶ moves provision for when a child of a group member may be denied eligibility;
- 35       ▶ clarifies preferred provider contract provisions;
- 36       ▶ addresses when a person is required to provide information concerning an employer
- 37 self-insured employee welfare benefit plan;
- 38       ▶ moves provisions related to alcohol and drug dependency treatment;
- 39       ▶ addresses groups eligible for group or blanket insurance;
- 40       ▶ modifies provisions related to requirements for notice of termination;
- 41       ▶ addresses scope of part of credit life and accident and health insurance;
- 42       ▶ amends definitions under the Unclaimed Life Insurance and Annuity Benefits Act;
- 43       ▶ provides for the assessment of forfeitures;
- 44       ▶ provides for notice to a producer of the termination of appointment;
- 45       ▶ addresses when an insurer contracts with a licensee;
- 46       ▶ imposes requirements related to flood insurance;
- 47       ▶ addresses licensed compensation;
- 48       ▶ provides for notice to a designee when an agency terminates the designation,
- 49 including navigator agencies;
- 50       ▶ addresses contracts with agencies;
- 51       ▶ addresses contracts with individual title insurance producer or an agency title
- 52 insurance producer;
- 53       ▶ requires certain record keeping requirements;
- 54       ▶ addresses reports from organizations licensed as adjusters;
- 55       ▶ enacts provisions related to adjusters;
- 56       ▶ modifies provisions related to captive insurers, including:

- 57 • amending definitions;
- 58 • addressing permissive areas of insurance;
- 59 • addressing capital issues;
- 60 • modifying provisions required for formation;
- 61 • providing that captive insurance companies may cede risks to certain insurers;
- 62 • addressing contributions to guaranty of insolvency funds; and
- 63 • repealing provisions related to an association captive or industrial insured

64 group;

- 65 ▶ amends board of directors provisions under the Defined Contribution Risk Adjuster
- 66 Act;
- 67 ▶ imposes record retention requirements under the Continuing Care Provider Act; and
- 68 ▶ makes technical and conforming amendments.

69 **Money Appropriated in this Bill:**

70 None

71 **Other Special Clauses:**

72 This bill provides retrospective operation.

73 **Utah Code Sections Affected:**

74 AMENDS:

- 75 **31A-2-308**, as last amended by Laws of Utah 2012, Chapter 253
- 76 **31A-3-102**, as last amended by Laws of Utah 2014, Chapter 435
- 77 **31A-3-205**, as enacted by Laws of Utah 2005, Chapter 123
- 78 **31A-3-304**, as last amended by Laws of Utah 2015, Chapter 244
- 79 **31A-8-402.3**, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
- 80 **31A-8-402.5**, as last amended by Laws of Utah 2003, Chapter 252
- 81 **31A-16-105**, as last amended by Laws of Utah 2015, Chapter 244
- 82 **31A-17-404**, as last amended by Laws of Utah 2016, Chapter 138
- 83 **31A-17-603**, as last amended by Laws of Utah 2013, Chapter 319
- 84 **31A-22-505**, as enacted by Laws of Utah 1985, Chapter 242
- 85 **31A-22-605**, as last amended by Laws of Utah 2005, Chapter 78
- 86 **31A-22-610.5**, as last amended by Laws of Utah 2011, Chapter 297
- 87 **31A-22-614.5**, as last amended by Laws of Utah 2011, Chapter 284

- 88            [31A-22-617](#), as last amended by Laws of Utah 2014, Chapters 290 and 300
- 89            [31A-22-701](#), as last amended by Laws of Utah 2011, Chapter 284
- 90            [31A-22-716](#), as last amended by Laws of Utah 2011, Chapters 284 and 297
- 91            [31A-22-721](#), as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
- 92            [31A-22-801](#), as last amended by Laws of Utah 2001, Chapter 116
- 93            [31A-22-1902](#), as enacted by Laws of Utah 2015, Chapter 259
- 94            [31A-23a-111](#), as last amended by Laws of Utah 2016, Chapter 138
- 95            [31A-23a-115](#), as last amended by Laws of Utah 2009, Chapter 349
- 96            [31A-23a-203](#), as last amended by Laws of Utah 2014, Chapters 290 and 300
- 97            [31A-23a-302](#), as last amended by Laws of Utah 2012, Chapter 253
- 98            [31A-23a-407](#), as last amended by Laws of Utah 2016, Chapter 314
- 99            [31A-23a-412](#), as last amended by Laws of Utah 2012, Chapter 253
- 100           [31A-23a-501](#), as last amended by Laws of Utah 2016, Chapter 138
- 101           [31A-23b-102](#), as last amended by Laws of Utah 2014, Chapters 290 and 300
- 102           [31A-23b-202.5](#), as enacted by Laws of Utah 2014, Chapter 425
- 103           [31A-23b-209](#), as enacted by Laws of Utah 2013, Chapter 341
- 104           [31A-23b-210](#), as enacted by Laws of Utah 2013, Chapter 341
- 105           [31A-23b-401](#), as last amended by Laws of Utah 2016, Chapter 138
- 106           [31A-26-209](#), as last amended by Laws of Utah 2004, Chapter 173
- 107           [31A-26-210](#), as last amended by Laws of Utah 2009, Chapter 349
- 108           [31A-26-213](#), as last amended by Laws of Utah 2016, Chapter 138
- 109           [31A-30-106](#), as last amended by Laws of Utah 2014, Chapters 290 and 300
- 110           [31A-30-106.1](#), as last amended by Laws of Utah 2012, Chapter 279
- 111           [31A-30-107](#), as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
- 112           [31A-30-107.1](#), as last amended by Laws of Utah 2003, Chapter 252
- 113           [31A-37-102](#), as last amended by Laws of Utah 2016, Chapter 138
- 114           [31A-37-106](#), as last amended by Laws of Utah 2015, Chapter 244
- 115           [31A-37-202](#), as last amended by Laws of Utah 2015, Chapter 244
- 116           [31A-37-204](#), as last amended by Laws of Utah 2016, Chapter 138
- 117           [31A-37-301](#), as last amended by Laws of Utah 2016, Chapter 348
- 118           [31A-37-303](#), as last amended by Laws of Utah 2016, Chapter 138

- 119            **31A-37-305**, as enacted by Laws of Utah 2003, Chapter 251
- 120            **31A-42-201**, as last amended by Laws of Utah 2010, Chapters 10 and 68
- 121            **31A-44-603**, as enacted by Laws of Utah 2016, Chapter 270
- 122            **53-2a-1102**, as last amended by Laws of Utah 2015, Chapter 408
- 123            **59-7-102**, as last amended by Laws of Utah 2014, Chapters 376 and 435
- 124            **59-9-101**, as last amended by Laws of Utah 2016, Chapter 135
- 125            **63G-2-302**, as last amended by Laws of Utah 2016, Chapter 410

126 ENACTS:

- 127            **31A-14-205.5**, Utah Code Annotated 1953
- 128            **31A-16a-101**, Utah Code Annotated 1953
- 129            **31A-16a-102**, Utah Code Annotated 1953
- 130            **31A-16a-103**, Utah Code Annotated 1953
- 131            **31A-16a-104**, Utah Code Annotated 1953
- 132            **31A-16a-105**, Utah Code Annotated 1953
- 133            **31A-16a-106**, Utah Code Annotated 1953
- 134            **31A-16a-107**, Utah Code Annotated 1953
- 135            **31A-16a-108**, Utah Code Annotated 1953
- 136            **31A-16a-109**, Utah Code Annotated 1953
- 137            **31A-16a-110**, Utah Code Annotated 1953
- 138            **31A-22-645**, Utah Code Annotated 1953
- 139            **31A-26-312**, Utah Code Annotated 1953
- 140            **31A-26-401**, Utah Code Annotated 1953
- 141            **31A-26-402**, Utah Code Annotated 1953
- 142            **31A-26-403**, Utah Code Annotated 1953

143 REPEALS:

- 144            **31A-22-715**, as last amended by Laws of Utah 2016, Chapter 138
- 145            **31A-22-718**, as enacted by Laws of Utah 1995, Chapter 344
- 146            **31A-37-306**, as last amended by Laws of Utah 2015, Chapter 244



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

149            Section 1. Section **31A-2-308** is amended to read:

150 **31A-2-308. Enforcement penalties and procedures.**

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

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

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

160 (c) (i) The commissioner may order an individual producer, surplus line producer,  
161 limited line producer, managing general agent, reinsurance intermediary, adjuster, third party  
162 administrator, navigator, or insurance consultant who violates an order issued under Subsection  
163 31A-2-201(4) to forfeit to the state not more than \$2,500 for each violation. Each day the  
164 violation continues is a separate violation.

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

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

171 (2) When a person fails to comply with an order issued under Subsection  
172 31A-2-201(4), including a forfeiture order, the commissioner may file an action in any court of  
173 competent jurisdiction or obtain a court order or judgment:

174 (a) enforcing the commissioner's order;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

211 (i) intentionally violates:

- 212 (A) an insurance statute of this state; or
- 213 (B) an order issued under Subsection 31A-2-201(4);
- 214 (ii) intentionally permits a person over whom that person has authority to violate:
- 215 (A) an insurance statute of this state; or
- 216 (B) an order issued under Subsection 31A-2-201(4); or
- 217 (iii) intentionally aids any person in violating:
- 218 (A) an insurance statute of this state; or
- 219 (B) an order issued under Subsection 31A-2-201(4).
- 220 (b) Unless a specific criminal penalty is provided elsewhere in this title, the person may
- 221 be fined not more than:
- 222 (i) \$10,000 if a corporation; or
- 223 (ii) \$5,000 if a person other than a corporation.
- 224 (c) If the person is an individual, the person may, in addition, be imprisoned for up to
- 225 one year.
- 226 (d) As used in this Subsection (9), "intentionally" has the same meaning as under
- 227 Subsection 76-2-103(1).
- 228 (10) (a) A person who knowingly and intentionally violates Section 31A-4-102,
- 229 31A-8a-208, 31A-15-105, 31A-23a-116, or 31A-31-111 is guilty of a felony as provided in this
- 230 Subsection (10).
- 231 (b) When the value of the property, money, or other things obtained or sought to be
- 232 obtained in violation of Subsection (10)(a):
- 233 (i) is less than \$5,000, a person is guilty of a third degree felony; or
- 234 (ii) is or exceeds \$5,000, a person is guilty of a second degree felony.
- 235 (11) (a) After a hearing, the commissioner may, in whole or in part, revoke, suspend,
- 236 place on probation, limit, or refuse to renew the licensee's license or certificate of authority:
- 237 (i) when a licensee of the department, other than a domestic insurer:
- 238 (A) persistently or substantially violates the insurance law; or
- 239 (B) violates an order of the commissioner under Subsection 31A-2-201(4);
- 240 (ii) if there are grounds for delinquency proceedings against the licensee under Section
- 241 31A-27a-207; or
- 242 (iii) if the licensee's methods and practices in the conduct of the licensee's business



243 endanger, or the licensee's financial resources are inadequate to safeguard, the legitimate  
244 interests of the licensee's customers and the public.

245 (b) Additional license termination or probation provisions for licensees other than  
246 insurers are set forth in Sections [31A-19a-303](#), [31A-19a-304](#), [31A-23a-111](#), [31A-23a-112](#),  
247 [31A-25-208](#), [31A-25-209](#), [31A-26-213](#), [31A-26-214](#), [31A-35-501](#), and [31A-35-503](#).

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

251 Section 2. Section **31A-3-102** is amended to read:

252 **31A-3-102. Exclusive fees and taxes.**

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

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

256 (b) the premium taxes under [Sections ~~59-9-101~~ through ~~59-9-104~~,] Title 59, Chapter  
257 9, Taxation of Admitted Insurers;

258 (c) the fees under Section [31A-31-108](#)[;]; and

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

262 [~~2~~ An]

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

265 (a) an insurer that is subject to premium taxes under [Sections ~~59-9-101~~ through  
266 ~~59-9-104~~ is not subject to corporate franchise taxes.] Title 59, Chapter 9, Taxation of Admitted  
267 Insurers, regardless of whether the insurance company has a tax liability under that chapter;

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

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

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

274 property taxes.

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

276 **31A-3-205. Taxation of insurance companies.**

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

279 (2) A surplus lines insurer shall pay the taxes due under Section [31A-3-301](#) or  
280 [31A-3-302](#) in accordance with Section [31A-3-303](#).

281 Section 4. Section **31A-3-304** is amended to read:

282 **31A-3-304. Annual fees -- Other taxes or fees prohibited -- Captive Insurance**  
283 **Restricted Account.**

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

286 (b) The commissioner shall:

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

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

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

292 ~~[(3)(a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter~~  
293 ~~9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under~~  
294 ~~the laws of this state that may be levied or assessed on a captive insurance company:]~~

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

298 (i) a fee under this section;

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

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

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

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

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

308 (4) A captive insurance company shall pay the fee imposed by this section to the  
309 commissioner by June 1 of each year.

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

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

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

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

319 (i) administer and enforce:

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

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

322 (ii) promote the captive insurance industry in Utah.

323 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,  
324 except that at the end of each fiscal year, money received by the commissioner in excess of the  
325 following shall be treated as free revenue in the General Fund:

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

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

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

329 Section 5. Section 31A-8-402.3 is amended to read:

330 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**  
331 **plans.**

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

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

335 (b) at the option of the plan sponsor.

336 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed for a  
337 network plan, if:

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

340 (i) the service area of the insurer; or

341 (ii) the area for which the insurer is authorized to do business; or

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

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

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

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

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

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

351 (c) the plan sponsor:

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

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

355 (d) the insurer:

356 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or  
357 issued for delivery in this state; and

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

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

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

361 (B) provides notice of the discontinuation in writing:

362 (I) to the commissioner; and

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

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

366 (I) all other health benefit [~~products~~] plans currently being offered by the insurer in the

367 market; or

368 (II) in the case of a large employer, any other health benefit [~~product~~] plan currently

369 being offered in that market; and

370 (D) in exercising the option to discontinue that [~~product~~] health benefit plan and in

371 offering the option of coverage in this section, acts uniformly without regard to:

372 (I) the claims experience of a plan sponsor;

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

374 (III) any health status-related factor relating to any new participant or beneficiary who

375 may become eligible for the coverage; or

376 (e) the insurer:

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

378 (A) the small employer market;

379 (B) the large employer market; or

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

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

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

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

384 (B) provides notice of the discontinuation in writing:

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

386 to reside; and

387 (II) at least 30 working days prior to the date the notice is sent to the affected plan

388 sponsors, employees, and the dependents of the plan sponsors or employees;

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

390 market; and

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

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

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

394 (b) for noncompliance with the insurer's:

395 (i) minimum participation requirements; or

396 (ii) employer contribution requirements.

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

- 398 (a) if a condition described in Subsection (2) exists; or  
399 (b) for noncompliance with the insurer's employer contribution requirements.  
400 (6) A small employer health benefit plan may be nonrenewed:  
401 (a) if a condition described in Subsection (2) exists; or  
402 (b) for noncompliance with the insurer's minimum participation requirements.  
403 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be  
404 discontinued if after issuance of coverage the eligible employee:  
405 (i) engages in an act or practice in connection with the coverage that constitutes fraud;  
406 or  
407 (ii) makes an intentional misrepresentation of material fact in connection with the  
408 coverage.  
409 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:  
410 (i) 12 months after the date of discontinuance; and  
411 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies  
412 to reenroll.  
413 (c) At the time the eligible employee's coverage is discontinued under Subsection  
414 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is  
415 discontinued.  
416 (d) An eligible employee may not be discontinued under this Subsection (7) because of  
417 a fraud or misrepresentation that relates to health status.  
418 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to  
419 the employer:  
420 (a) with respect to coverage provided to an employer member of the association; and  
421 (b) if the health benefit plan is made available by an insurer in the employer market  
422 only through:  
423 (i) an association;  
424 (ii) a trust; or  
425 (iii) a discretionary group.  
426 (9) An insurer may modify a health benefit plan for a plan sponsor only:  
427 (a) at the time of coverage renewal; and  
428 (b) if the modification is effective uniformly among all plans with that product.

429 Section 6. Section 31A-8-402.5 is amended to read:

430 **31A-8-402.5. Individual discontinuance and nonrenewal.**

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

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

434 (ii) at the option of the individual.

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

436 (i) whether the contract is issued through:

437 (A) a trust;

438 (B) an association;

439 (C) a discretionary group; or

440 (D) other similar grouping; or

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

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

443 (a) for a network plan, if:

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

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

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

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

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

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

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

453 (3) A health benefit plan may be discontinued if:

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

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

457 (c) the individual:

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

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

460 coverage;

461 (d) the insurer:

462 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or

463 issued for delivery in this state; and

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

465 (I) to each individual provided coverage; and

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

467 (B) provides notice of the discontinuation in writing:

468 (I) to the commissioner; and

469 (II) at least three working days prior to the date the notice is sent to the affected

470 individuals;

471 (C) offers to each covered individual on a guaranteed issue basis, the option to

472 purchase all other individual health benefit [~~products~~] plans currently being offered by the

473 insurer for individuals in that market; and

474 (D) acts uniformly without regard to any health status-related factor of covered

475 individuals or dependents of covered individuals who may become eligible for coverage; or

476 (e) the insurer:

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

478 and

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

480 (I) to each individual provided coverage; and

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

482 (B) provides notice of the discontinuation in writing:

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

484 to reside; and

485 (II) at least 30 working days prior to the date the notice is sent to the affected

486 individuals;

487 (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers

488 for issuance in the individual market; and

489 (D) acts uniformly without regard to any health status-related factor of covered

490 individuals or dependents of covered individuals who may become eligible for coverage.



491 Section 7. Section 31A-14-205.5 is enacted to read:

492 **31A-14-205.5. Place of business address information -- Record retention.**

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

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

495 of business; and

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

497 (b) A licensee shall notify the commissioner within 30 days of a change of any of the

498 following required to be registered with the commissioner under this section:

499 (i) an address;

500 (ii) a telephone number; or

501 (iii) a business email address.

502 (2) (a) Except as provided under Subsection (3), a licensee under this chapter shall

503 keep at the address of the principal place of business registered under Subsection (1), separate

504 and distinct books and records of the transactions consummated under the Utah license.

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

506 (i) be in an organized form; and

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

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

509 (i) if the licensee is a foreign insurer, alien insurer, commercially domiciled insurer,

510 foreign title insurer, or foreign fraternal:

511 (A) a record of each insurance contract procured by or issued through the licensee, with

512 the names of the one or more insureds, the amount of premium and commissions or other

513 compensation, and the subject of the insurance;

514 (B) the name of any other producer, surplus lines producer, limited line producer,

515 consultant, managing general agent, or reinsurance intermediary from whom business is

516 accepted, and of a person to whom commissions or allowances of any kind are promised or

517 paid; and

518 (C) a record of the consumer complaints forwarded to the licensee by an insurance

519 regulator; and

520 (ii) any additional information that:

521 (A) is customary for a similar business; or

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

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

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

530 (5) (a) The books and records maintained under Subsection (2) shall be available for  
531 the inspection of the commissioner during the business hours for a period of time after the date  
532 of the transaction as specified by the commissioner by rule, made in accordance with Title  
533 63G, Chapter 3, Utah Administrative Rulemaking Act, but in no case for less than three  
534 calendar years in addition to the current calendar year.

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

537 Section 8. Section **31A-16-105** is amended to read:

538 **31A-16-105. Registration of insurers.**

539 (1) (a) An insurer that is authorized to do business in this state and that is a member of  
540 an insurance holding company system shall register with the commissioner, except a foreign  
541 insurer subject to registration requirements and standards adopted by statute or regulation in the  
542 jurisdiction of its domicile, if the requirements and standards are substantially similar to those  
543 contained in this section, Subsections **31A-16-106**(1)(a) and (2) and either Subsection  
544 **31A-16-106**(1)(b) or a statutory provision similar to the following: "Each registered insurer  
545 shall keep current the information required to be disclosed in its registration statement by  
546 reporting all material changes or additions within 15 days after the end of the month in which it  
547 learns of each change or addition."

548 (b) An insurer that is subject to registration under this section shall register within 15  
549 days after it becomes subject to registration, and annually thereafter by ~~May 1~~ June 30 of each  
550 year for the previous calendar year, unless the commissioner for good cause extends the time  
551 for registration and then at the end of the extended time period. The commissioner may require  
552 any insurer authorized to do business in the state, which is a member of a holding company

553 system, and which is not subject to registration under this section, to furnish a copy of the  
554 registration statement, the summary specified in Subsection (3), or any other information filed  
555 by the insurer with the insurance regulatory authority of domiciliary jurisdiction.

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

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

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

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

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

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

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

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

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

573 (vi) reinsurance agreements;

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

575 (viii) consolidated tax allocation agreements;

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

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

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

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

584 filed parent corporation financial statements that have been filed with the United States  
585 Securities and Exchange Commission;

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

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

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

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

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

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

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

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

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

613 (9) The commissioner may allow an insurer which is authorized to do business in this  
614 state, and which is part of an insurance holding company system, to register on behalf of any

615 affiliated insurer which is required to register under Subsection (1) and to file all information  
616 and material required to be filed under this section.

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

619 (11) Any person may file with the commissioner a disclaimer of affiliation with any  
620 authorized insurer, or a disclaimer of affiliation may be filed by any insurer or any member of  
621 an insurance holding company system. The disclaimer shall fully disclose all material  
622 relationships and bases for affiliation between the person and the insurer as well as the basis for  
623 disclaiming the affiliation. A disclaimer of affiliation is considered to have been granted  
624 unless the commissioner, within 30 days following receipt of a complete disclaimer, notifies  
625 the filing party the disclaimer is disallowed. If disallowed, the disclaiming party may request  
626 an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its  
627 duty to register under this section if approval of the disclaimer is granted by the commissioner,  
628 or if the disclaimer is considered to have been approved.

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

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

639 Section 9. Section **31A-16a-101** is enacted to read:

640 **CHAPTER 16a. RISK MANAGEMENT AND OWN RISK AND**  
641 **SOLVENCY ASSESSMENT ACT**

642 **31A-16a-101. Title -- Scope.**

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

645 (2) This chapter applies to an insurer domiciled in this state unless exempt pursuant to

646 Section 31A-16a-106.

647 Section 10. Section **31A-16a-102** is enacted to read:

648 **31A-16a-102. Definitions.**

649 As used in this chapter:

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

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

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

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

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

667 Section 11. Section **31A-16a-103** is enacted to read:

668 **31A-16a-103. Risk management framework.**

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

673 Section 12. Section **31A-16a-104** is enacted to read:

674 **31A-16a-104. Own risk and solvency assessment requirement.**

675 Subject to Section 31A-16a-106, an insurer, or the insurance group of which the insurer  
676 is a member, shall regularly conduct an own risk and solvency assessment consistent with a

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

681 Section 13. Section **31A-16a-105** is enacted to read:

682 **31A-16a-105. ORSA summary report.**

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

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

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

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

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

700 (3) An insurer may comply with Subsection (1) by providing the most recent and  
701 substantially similar one or more reports provided by the insurer or another member of an  
702 insurance group of which the insurer is a member to the commissioner of another state or to a  
703 supervisor or regulator of a foreign jurisdiction, if that report provides information that is  
704 comparable to the information described in the ORSA guidance manual. A report that is in a  
705 language other than English must be accompanied by a translation of that report into the  
706 English language.

707 Section 14. Section **31A-16a-106** is enacted to read:

708 31A-16a-106. Exemption.709 (1) An insurer shall be exempt from the requirements of this chapter, if:710 (a) the insurer has annual direct written and unaffiliated assumed premium, including  
711 international direct and assumed premium, but excluding premiums reinsured with the Federal  
712 Crop Insurance Corporation and Federal Flood Program, less than \$500,000,000; and713 (b) the insurance group of which the insurer is a member has annual direct written and  
714 unaffiliated assumed premium, including international direct and assumed premium, but  
715 excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood  
716 Program, less than \$1,000,000,000.717 (2) If an insurer qualifies for exemption pursuant to Subsection (1)(a), but the  
718 insurance group of which the insurer is a member does not qualify for exemption pursuant to  
719 Subsection (1)(b), the ORSA summary report that is required pursuant to Section [31A-16a-105](#)  
720 shall include every insurer within the insurance group. This requirement may be satisfied by the  
721 submission of more than one ORSA summary report for any combination of insurers provided  
722 any combination of reports includes every insurer within the insurance group.723 (3) If an insurer does not qualify for exemption pursuant to Subsection (1)(a), but the  
724 insurance group of which it is a member qualifies for exemption pursuant to Subsection (1)(b),  
725 the only ORSA summary report that may be required pursuant Section [31A-16a-105](#) shall be  
726 the report applicable to that insurer.727 (4) An insurer that does not qualify for exemption pursuant to Subsection (1) may  
728 apply to the commissioner for a waiver from the requirements of this chapter based upon  
729 unique circumstances. In deciding whether to grant the insurer's request for waiver, the  
730 commissioner may consider the type and volume of business written, ownership and  
731 organizational structure, and any other factor the commissioner considers relevant to the  
732 insurer or insurance group of which the insurer is a member. If the insurer is part of an  
733 insurance group with insurers domiciled in more than one state, the commissioner shall  
734 coordinate with the lead state commissioner and with the other domiciliary commissioners in  
735 considering whether to grant the insurer's request for a waiver.736 (5) Notwithstanding the exemptions stated in this section:737 (a) the commissioner may require that an insurer maintain a risk management  
738 framework, conduct an own risk and solvency assessment, and file an ORSA summary report



739 based on unique circumstances, including the type and volume of business written, ownership  
740 and organizational structure, federal agency requests, and international supervisor requests; or  
741 (b) the commissioner may require that an insurer maintain a risk management  
742 framework, conduct an own risk and solvency assessment and file an ORSA summary report if  
743 the insurer has risk-based capital for company action level event as set forth in Sections  
744 31A-17-601 through 31A-17-613, meets one or more of the standards of an insurer considered  
745 to be in hazardous financial condition as defined in Section 31A-27a-101, or otherwise exhibits  
746 qualities of a troubled insurer as determined by the commissioner.

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

753 Section 15. Section **31A-16a-107** is enacted to read:

754 **31A-16a-107. Contents of ORSA summary report.**

755 (1) The ORSA summary report shall be prepared consistent with the ORSA guidance  
756 manual, subject to the requirements of Subsection (2). Documentation supporting information  
757 shall be maintained and made available upon examination or upon request of the  
758 commissioner.

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

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

763 **31A-16a-108. Confidentiality.**

764 (1) (a) A document, material, or other information, including the ORSA summary  
765 report, in the possession of or control of the department that is obtained by, created by, or  
766 disclosed to the commissioner or any other person under this chapter, is recognized by this state  
767 as being proprietary and to contain trade secrets. The document, material, or other information  
768 is confidential and may not be subject to Title 63G, Chapter 2, Government Records Access  
769 and Management Act, and may not be made public by the commissioner or any other person

770 without the permission of the insurer.

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

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

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

782 (a) may, upon request, share a document, material, or other information related to an  
783 own risk solvency assessment, including a confidential document, material, or information  
784 subject to Subsection (1), including proprietary and trade secret documents and materials with  
785 other state, federal, and international financial regulatory agencies, including members of any  
786 supervisory college as described in the Section [31A-16-108.5](#), with the National Association of  
787 Insurance Commissioners and with any third-party consultants designated by the  
788 commissioner, provided that the recipient agrees in writing to maintain the confidentiality of  
789 documents, materials, or other information related to an own risk and solvency assessment and  
790 has verified in writing the legal authority to maintain confidentiality;

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

800 (c) shall enter into a written agreement with the National Association of Insurance

801 Commissioners or a third-party consultant governing sharing and use of information provided  
802 pursuant to this chapter, consistent with this Subsection (3) that shall:

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

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

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

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

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

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

831 (4) The sharing of information or a document by the commissioner pursuant to this

832 chapter does not constitute a delegation of regulatory authority or rulemaking, and the  
833 commissioner is solely responsible for the administration, execution, and enforcement of this  
834 chapter.

835 (5) A waiver of an applicable claim of confidentiality in a document, proprietary and  
836 trade-secret material, or other information related to an own risk and solvency assessment may  
837 not occur as a result of disclosure of the own risk and solvency assessment related information  
838 or a document to the commissioner under this section or as a result of sharing as authorized in  
839 this chapter.

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

843 (a) confidential, not a public record, and not open to public inspection; and  
844 (b) not subject to Title 63G, Chapter 2, Government Records Access and Management  
845 Act.

846 Section 17. Section **31A-16a-109** is enacted to read:

847 **31A-16a-109. Sanctions.**

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

855 Section 18. Section **31A-16a-110** is enacted to read:

856 **31A-16a-110. Severability Clause.**

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

861 Section 19. Section **31A-17-404** is amended to read:

862 **31A-17-404. Credit allowed a domestic ceding insurer against reserves for**

863 **reinsurance.**

864 (1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a  
865 reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of  
866 Subsection (3), (4), (5), (6), (7), or (8), subject to the following:

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

870 (i) in its state of domicile; or

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

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

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

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

877 (b) only to the extent that the accounting:

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

879 (ii) clearly reflects:

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

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

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

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

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

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

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

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

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

894 (iii) (A) is licensed to transact insurance or reinsurance in at least one state; or  
895 (B) in the case of a United States branch of an alien assuming insurer, is entered  
896 through and licensed to transact insurance or reinsurance in at least one state;  
897 (iv) files annually with the commissioner a copy of the insurer's:  
898 (A) annual statement filed with the insurance department of its state of domicile; and  
899 (B) most recent audited financial statement; and  
900 (v) (A) (I) has not had its accreditation denied by the commissioner within 90 days of  
901 the day on which the insurer submits the information required by this Subsection (4); and  
902 (II) maintains a surplus with regard to policyholders in an amount not less than  
903 \$20,000,000; or  
904 (B) (I) has its accreditation approved by the commissioner; and  
905 (II) maintains a surplus with regard to policyholders in an amount less than  
906 \$20,000,000.  
907 (c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's  
908 accreditation is revoked by the commissioner after a notice and hearing.  
909 (5) (a) A domestic ceding insurer is allowed a credit if:  
910 (i) the reinsurance is ceded to an assuming insurer that is:  
911 (A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or  
912 (B) in the case of a United States branch of an alien assuming insurer, is entered  
913 through a state meeting the requirements of Subsection (5)(a)(ii);  
914 (ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for  
915 reinsurance substantially similar to those applicable under this section; and  
916 (iii) the assuming insurer or United States branch of an alien assuming insurer:  
917 (A) maintains a surplus with regard to policyholders in an amount not less than  
918 \$20,000,000; and  
919 (B) submits to the authority of the commissioner to examine its books and records.  
920 (b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded  
921 and assumed pursuant to a pooling arrangement among insurers in the same holding company  
922 system.  
923 (6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an  
924 assuming insurer that maintains a trust fund:

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

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

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

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

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

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

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

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

937 (B) pay the cost of an examination.

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

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

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

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

945 (iii) The trust instrument shall provide that a contested claim is valid and enforceable  
946 upon the final order of a court of competent jurisdiction in the United States.

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

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

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

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

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

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

- 956 (vii) No later than February 28 of each year, the trustee of the trust shall:
- 957 (A) report to the commissioner in writing the balance of the trust;
- 958 (B) list the trust's investments at the end of the preceding calendar year; and
- 959 (C) (I) certify the date of termination of the trust, if so planned; or
- 960 (II) certify that the trust will not expire prior to the following December 31.
- 961 (d) The following requirements apply to the following categories of assuming insurer:
- 962 (i) For a single assuming insurer:
- 963 (A) the trust fund shall consist of funds in trust in an amount not less than the assuming
- 964 insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and
- 965 (B) the assuming insurer shall maintain a trusteed surplus of not less than \$20,000,000,
- 966 except as provided in Subsection (6)(d)(ii).
- 967 (ii) (A) At any time after the assuming insurer has permanently discontinued
- 968 underwriting new business secured by the trust for at least three full years, the commissioner
- 969 with principal regulatory oversight of the trust may authorize a reduction in the required
- 970 trusteed surplus, but only after a finding, based on an assessment of the risk, that the new
- 971 required surplus level is adequate for the protection of United States ceding insurers,
- 972 policyholders, and claimants in light of reasonably foreseeable adverse loss development.
- 973 (B) The risk assessment may involve an actuarial review, including an independent
- 974 analysis of reserves and cash flows, and shall consider all material risk factors, including, when
- 975 applicable, the lines of business involved, the stability of the incurred loss estimates, and the
- 976 effect of the surplus requirements on the assuming insurer's liquidity or solvency.
- 977 (C) The minimum required trusteed surplus may not be reduced to an amount less than
- 978 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States
- 979 ceding insurers covered by the trust.
- 980 (iii) For a group acting as assuming insurer, including incorporated and individual
- 981 unincorporated underwriters:
- 982 (A) for reinsurance ceded under a reinsurance agreement with an inception,
- 983 amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed
- 984 account in an amount not less than the respective underwriters' several liabilities attributable to
- 985 business ceded by the one or more United States domiciled ceding insurers to an underwriter of
- 986 the group;



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

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

996 (D) the incorporated members of the group:

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

999 (II) are subject to the same level of regulation and solvency control by the group's  
1000 domiciliary regulator as are the unincorporated members; and

1001 (E) within 90 days after the day on which the group's financial statements are due to be  
1002 filed with the group's domiciliary regulator, the group shall provide to the commissioner:

1003 (I) an annual certification by the group's domiciliary regulator of the solvency of each  
1004 underwriter member; or

1005 (II) if a certification is unavailable, a financial statement, prepared by an independent  
1006 public accountant, of each underwriter member of the group.

1007 (iv) For a group of incorporated underwriters under common administration, the group  
1008 shall:

1009 (A) have continuously transacted an insurance business outside the United States for at  
1010 least three years immediately preceding the day on which the group makes application for  
1011 accreditation;

1012 (B) maintain aggregate policyholders' surplus of at least \$10,000,000,000;

1013 (C) maintain a trust fund in an amount not less than the group's several liabilities  
1014 attributable to business ceded by the one or more United States domiciled ceding insurers to a  
1015 member of the group pursuant to a reinsurance contract issued in the name of the group;

1016 (D) in addition to complying with the other provisions of this Subsection (6)(d)(iv),  
1017 maintain a joint trustee surplus of which \$100,000,000 is held jointly for the benefit of the one

1018 or more United States domiciled ceding insurers of a member of the group as additional  
1019 security for these liabilities; and

1020 (E) within 90 days after the day on which the group's financial statements are due to be  
1021 filed with the group's domiciliary regulator, make available to the commissioner:

1022 (I) an annual certification of each underwriter member's solvency by the member's  
1023 domiciliary regulator; and

1024 (II) a financial statement of each underwriter member of the group prepared by an  
1025 independent public accountant.

1026 (7) If reinsurance is ceded to an assuming insurer not meeting the requirements of  
1027 Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the  
1028 insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law  
1029 or regulation of that jurisdiction.

1030 (8) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an  
1031 assuming insurer that secures its obligations in accordance with this Subsection (8):

1032 (a) The insurer shall be certified by the commissioner as a reinsurer in this state.

1033 (b) To be eligible for certification, the assuming insurer shall:

1034 (i) be domiciled and licensed to transact insurance or reinsurance in a qualified  
1035 jurisdiction, as determined by the commissioner pursuant to Subsection (8)(d);

1036 (ii) maintain minimum capital and surplus, or its equivalent, in an amount to be  
1037 determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter  
1038 3, Utah Administrative Rulemaking Act;

1039 (iii) maintain financial strength ratings from two or more rating agencies considered  
1040 acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter  
1041 3, Utah Administrative Rulemaking Act; and

1042 (iv) agree to:

1043 (A) submit to the jurisdiction of this state;

1044 (B) appoint the commissioner as its agent for service of process in this state;

1045 (C) provide security for 100% of the assuming insurer's liabilities attributable to  
1046 reinsurance ceded by United States ceding insurers if it resists enforcement of a final United  
1047 States judgment;

1048 (D) agree to meet applicable information filing requirements as determined by the

1049 commissioner including an application for certification, a renewal and on an ongoing basis; and

1050 (E) any other requirements for certification considered relevant by the commissioner.

1051 (c) An association, including incorporated and individual unincorporated underwriters,

1052 may be a certified reinsurer. To be eligible for certification, in addition to satisfying

1053 requirements of Subsections (8)(a) and (b), the association:

1054 (i) shall satisfy its minimum capital and surplus requirements through the capital and

1055 surplus equivalents, net of liabilities, of the association and its members, which shall include a

1056 joint central fund that may be applied to any unsatisfied obligation of the association or any of

1057 its members in an amount determined by the commissioner to provide adequate protection;

1058 (ii) may not have incorporated members of the association engaged in any business

1059 other than underwriting as a member of the association;

1060 (iii) shall be subject to the same level of regulation and solvency control of the

1061 incorporated members of the association by the association's domiciliary regulator as are the

1062 unincorporated members; and

1063 (iv) within 90 days after its financial statements are due to be filed with the

1064 association's domiciliary regulator provide:

1065 (A) to the commissioner an annual certification by the association's domiciliary

1066 regulator of the solvency of each underwriter member; or

1067 (B) if a certification is unavailable, financial statements prepared by independent

1068 public accountants, of each underwriter member of the association.

1069 (d) The commissioner shall create and publish a list of qualified jurisdictions under

1070 which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be

1071 considered for certification by the commissioner as a certified reinsurer.

1072 (i) To determine whether the domiciliary jurisdiction of a non-United States assuming

1073 insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:

1074 (A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory

1075 system of the jurisdiction, both initially and on an ongoing basis;

1076 (B) shall consider the rights, the benefits, and the extent of reciprocal recognition

1077 afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the

1078 United States;

1079 (C) shall require the qualified jurisdiction to share information and cooperate with the

1080 commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and

1081 (D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has  
1082 determined that the jurisdiction does not adequately and promptly enforce final United States  
1083 judgments and arbitration awards.

1084 (ii) The commissioner may consider additional factors in determining a qualified  
1085 jurisdiction.

1086 (iii) A list of qualified jurisdictions shall be published through the National  
1087 Association of Insurance Commissioners' Committee Process and the commissioner shall:

1088 (A) consider this list in determining qualified jurisdictions; and

1089 (B) if the commissioner approves a jurisdiction as qualified that does not appear on the  
1090 National Association of Insurance Commissioner's list of qualified jurisdictions, provide  
1091 thoroughly documented justification in accordance with criteria to be developed by rule made  
1092 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

1093 (iv) United States jurisdictions that meet the requirement for accreditation under the  
1094 National Association of Insurance Commissioners' financial standards and accreditation  
1095 program shall be recognized as qualified jurisdictions.

1096 (v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction,  
1097 the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.

1098 (e) The commissioner shall:

1099 (i) assign a rating to each certified reinsurer, giving due consideration to the financial  
1100 strength ratings that have been assigned by rating agencies considered acceptable to the  
1101 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative  
1102 Rulemaking Act; and

1103 (ii) publish a list of all certified reinsurers and their ratings.

1104 (f) A certified reinsurer shall secure obligations assumed from United States ceding  
1105 insurers under this Subsection (8) at a level consistent with its rating, as specified in rules made  
1106 by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative  
1107 Rulemaking Act.

1108 (i) For a domestic ceding insurer to qualify for full financial statement credit for  
1109 reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a  
1110 form acceptable to the commissioner and consistent with Section [31A-17-404.1](#), or in a

1111 multibeneficiary trust in accordance with Subsections (5), (6), and (7), except as otherwise  
1112 provided in this Subsection (8).

1113 (ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to  
1114 Subsections (5), (6), and (7), and chooses to secure its obligations incurred as a certified  
1115 reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate  
1116 trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a  
1117 certified reinsurer with reduced security as permitted by this Subsection (8) or comparable laws  
1118 of other United States jurisdictions and for its obligations subject to Subsections (5), (6), and  
1119 (7).

1120 (iii) It shall be a condition to the grant of certification under this Subsection (8) that the  
1121 certified reinsurer shall have bound itself<sup>[-]</sup>:

1122 (A) by the language of the trust and agreement with the commissioner with principal  
1123 regulatory oversight of the trust account<sup>[-]</sup>; and

1124 (B) upon termination of the trust account, to fund, [~~upon termination of the trust~~  
1125 ~~account~~], out of the remaining surplus of the trust, any deficiency of any other [~~the~~] trust  
1126 account.

1127 (iv) The minimum trusteed surplus requirements provided in Subsections (5), (6), and  
1128 (7) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer  
1129 for the purpose of securing obligations incurred under this Subsection (8), except that the trust  
1130 shall maintain a minimum trusteed surplus of \$10,000,000.

1131 (v) With respect to obligations incurred by a certified reinsurer under this Subsection  
1132 (8), if the security is insufficient, the commissioner:

1133 (A) shall reduce the allowable credit by an amount proportionate to the deficiency; and

1134 (B) may impose further reductions in allowable credit upon finding that there is a  
1135 material risk that the certified reinsurer's obligations will not be paid in full when due.

1136 (vi) For purposes of this Subsection (8), a certified reinsurer whose certification has  
1137 been terminated for any reason shall be treated as a certified reinsurer required to secure 100%  
1138 of its obligations.

1139 (A) As used in this Subsection (8), the term "terminated" refers to revocation,  
1140 suspension, voluntary surrender, and inactive status.

1141 (B) If the commissioner continues to assign a higher rating as permitted by other

1142 provisions of this section, the requirement under this Subsection (8)(f)(vi) does not apply to a  
1143 certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

1144 (g) If an applicant for certification has been certified as a reinsurer in a National  
1145 Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:

1146 (i) defer to that jurisdiction's certification;

1147 (ii) defer to the rating assigned by that jurisdiction; and

1148 (iii) consider such reinsurer to be a certified reinsurer in this state.

1149 (h) (i) A certified reinsurer that ceases to assume new business in this state may request  
1150 to maintain its certification in inactive status in order to continue to qualify for a reduction in  
1151 security for its in-force business.

1152 (ii) An inactive certified reinsurer shall continue to comply with all applicable  
1153 requirements of this Subsection (8).

1154 (iii) The commissioner shall assign a rating to a reinsurer that qualifies under this  
1155 Subsection (8)(h), that takes into account, if relevant, the reasons why the reinsurer is not  
1156 assuming new business.

1157 (9) Reinsurance credit may not be allowed a domestic ceding insurer unless the  
1158 assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

1159 (a) (i) being an admitted insurer; and

1160 (ii) submitting to jurisdiction under Section [31A-2-309](#);

1161 (b) having irrevocably appointed the commissioner as the domestic ceding insurer's  
1162 agent for service of process in an action arising out of or in connection with the reinsurance,  
1163 which appointment is made under Section [31A-2-309](#); or

1164 (c) agreeing in the reinsurance contract:

1165 (i) that if the assuming insurer fails to perform its obligations under the terms of the  
1166 reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

1167 (A) submit to the jurisdiction of a court of competent jurisdiction in a state of the  
1168 United States;

1169 (B) comply with all requirements necessary to give the court jurisdiction; and

1170 (C) abide by the final decision of the court or of an appellate court in the event of an  
1171 appeal; and

1172 (ii) to designate the commissioner or a specific attorney licensed to practice law in this

1173 state as its attorney upon whom may be served lawful process in an action, suit, or proceeding  
1174 instituted by or on behalf of the ceding company.

1175 (10) Submitting to the jurisdiction of Utah courts under Subsection (9) does not  
1176 override a duty or right of a party under the reinsurance contract, including a requirement that  
1177 the parties arbitrate their disputes.

1178 (11) If an assuming insurer does not meet the requirements of Subsection (3), (4), or  
1179 (5), the credit permitted by Subsection (6) or (8) may not be allowed unless the assuming  
1180 insurer agrees in the trust instrument to the following conditions:

1181 (a) (i) Notwithstanding any other provision in the trust instrument, if an event  
1182 described in Subsection (11)(a)(ii) occurs the trustee shall comply with:

1183 (A) an order of the commissioner with regulatory oversight over the trust; or

1184 (B) an order of a court of competent jurisdiction directing the trustee to transfer to the  
1185 commissioner with regulatory oversight all of the assets of the trust fund.

1186 (ii) This Subsection (11)(a) applies if:

1187 (A) the trust fund is inadequate because the trust contains an amount less than the  
1188 amount required by Subsection (6)(d); or

1189 (B) the grantor of the trust is:

1190 (I) declared insolvent; or

1191 (II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the  
1192 laws of its state or country of domicile.

1193 (b) The assets of a trust fund described in Subsection (11)(a) shall be distributed by and  
1194 a claim shall be filed with and valued by the commissioner with regulatory oversight in  
1195 accordance with the laws of the state in which the trust is domiciled that are applicable to the  
1196 liquidation of a domestic insurance company.

1197 (c) If the commissioner with regulatory oversight determines that the assets of the trust  
1198 fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United  
1199 States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be  
1200 returned by the commissioner with regulatory oversight to the trustee for distribution in  
1201 accordance with the trust instrument.

1202 (d) A grantor shall waive any right otherwise available to it under United States law  
1203 that is inconsistent with this Subsection (11).

1204 (12) If an accredited or certified reinsurer ceases to meet the requirements for  
1205 accreditation or certification, the commissioner may suspend or revoke the reinsurer's  
1206 accreditation or certification.

1207 (a) The commissioner shall give the reinsurer notice and opportunity for hearing.

1208 (b) The suspension or revocation may not take effect until after the commissioner's  
1209 order after a hearing, unless:

1210 (i) the reinsurer waives its right to hearing;

1211 (ii) the commissioner's order is based on:

1212 (A) regulatory action by the reinsurer's domiciliary jurisdiction; or

1213 (B) the voluntary surrender or termination of the reinsurer's eligibility to transact  
1214 insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state  
1215 under Subsection (8)(g); or

1216 (iii) the commissioner's finding that an emergency requires immediate action and a  
1217 court of competent jurisdiction has not stayed the commissioner's action.

1218 (c) While a reinsurer's accreditation or certification is suspended, no reinsurance  
1219 contract issued or renewed after the effective date of the suspension qualifies for credit except  
1220 to the extent that the reinsurer's obligations under the contract are secured in accordance with  
1221 Section [31A-17-404.1](#).

1222 (d) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance  
1223 may be granted after the effective date of the revocation except to the extent that the reinsurer's  
1224 obligations under the contract are secured in accordance with Subsection (8)(f) or Section  
1225 [31A-17-404.1](#).

1226 (13) (a) A ceding insurer shall take steps to manage its reinsurance recoverables  
1227 proportionate to its own book of business.

1228 (b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after  
1229 reinsurance recoverables from any single assuming insurer, or group of affiliated assuming  
1230 insurers:

1231 (A) exceeds 50% of the domestic ceding insurer's last reported surplus to  
1232 policyholders; or

1233 (B) after it is determined that reinsurance recoverables from any single assuming  
1234 insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding



1235 insurer's last reported surplus to policyholders.

1236 (ii) The notification required by Subsection (13)(b)(i) shall demonstrate that the  
1237 exposure is safely managed by the domestic ceding insurer.

1238 (c) A ceding insurer shall take steps to diversify its reinsurance program.

1239 (d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after  
1240 ceding or being likely to cede more than 20% of the ceding insurer's gross written premium in  
1241 the prior calendar year to any:

1242 (A) single assuming insurer; or

1243 (B) group of affiliated assuming insurers.

1244 (ii) The notification shall demonstrate that the exposure is safely managed by the  
1245 domestic ceding insurer.

1246 Section 20. Section **31A-17-603** is amended to read:

1247 **31A-17-603. Company action level event.**

1248 (1) "Company action level event" means any of the following events:

1249 (a) the filing of an RBC report by an insurer or health organization that indicates that:

1250 (i) the insurer's or health organization's total adjusted capital is greater than or equal to  
1251 its regulatory action level RBC but less than its company action level RBC;

1252 (ii) if a life ~~[or]~~ insurer, accident and health insurer, or health organization, the insurer  
1253 ~~[has]~~ or health organization:

1254 (A) has total adjusted capital that is greater than or equal to its company action level  
1255 RBC but less than the product of its authorized control level RBC and 3.0; and

1256 (B) triggers the trend test determined in accordance with the trend test calculation  
1257 included in the life ~~[or]~~, fraternal, or health RBC instructions; or

1258 (iii) if a property and casualty insurer, the insurer has:

1259 (A) total adjusted capital that is greater than or equal to its company action level RBC,  
1260 but less than the product of its authorized control level RBC and 3.0; and

1261 (B) triggers the trend test determined in accordance with the trend test calculation  
1262 included in the property and casualty RBC instructions;

1263 (b) the notification by the commissioner to the insurer or health organization of an  
1264 adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health  
1265 organization does not challenge the adjusted RBC report under Section **31A-17-607**; or

1266 (c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an  
1267 adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the  
1268 commissioner to the insurer or health organization that after a hearing the commissioner rejects  
1269 the insurer's or health organization's challenge.

1270 (2) (a) In the event of a company action level event, the insurer or health organization  
1271 shall prepare and submit to the commissioner an RBC plan that shall:

1272 (i) identify the conditions that contribute to the company action level event;

1273 (ii) contain proposals of corrective actions that the insurer or health organization  
1274 intends to take and that are expected to result in the elimination of the company action level  
1275 event;

1276 (iii) provide projections of the insurer's or health organization's financial results in the  
1277 current year and at least the four succeeding years, both in the absence of proposed corrective  
1278 actions and giving effect to the proposed corrective actions, including projections of:

1279 (A) statutory operating income;

1280 (B) net income;

1281 (C) capital;

1282 (D) surplus; and

1283 (E) RBC levels;

1284 (iv) identify the key assumptions impacting the insurer's or health organization's  
1285 projections and the sensitivity of the projections to the assumptions; and

1286 (v) identify the quality of, and problems associated with, the insurer's or health  
1287 organization's business, including its assets, anticipated business growth and associated surplus  
1288 strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each  
1289 case.

1290 (b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal  
1291 business may include separate projections for each major line of business and separately  
1292 identify each significant income, expense, and benefit component.

1293 (3) The RBC plan shall be submitted:

1294 (a) within 45 days of the company action level event; or

1295 (b) if the insurer or health organization challenges an adjusted RBC report pursuant to  
1296 Section 31A-17-607, within 45 days after notification to the insurer or health organization that

1297 after a hearing the commissioner rejects the insurer's or health organization's challenge.

1298 (4) (a) Within 60 days after the submission by an insurer or health organization of an  
1299 RBC plan to the commissioner, the commissioner shall notify the insurer or health organization  
1300 whether the RBC plan:

1301 (i) shall be implemented; or

1302 (ii) is unsatisfactory.

1303 (b) If the commissioner determines the RBC plan is unsatisfactory, the notification to  
1304 the insurer or health organization shall set forth the reasons for the determination, and may  
1305 propose revisions that will render the RBC plan satisfactory. Upon notification from the  
1306 commissioner, the insurer or health organization shall:

1307 (i) prepare a revised RBC plan that incorporates any revision proposed by the  
1308 commissioner; and

1309 (ii) submit the revised RBC plan to the commissioner:

1310 (A) within 45 days after the notification from the commissioner; or

1311 (B) if the insurer challenges the notification from the commissioner under Section  
1312 [31A-17-607](#), within 45 days after a notification to the insurer or health organization that after a  
1313 hearing the commissioner rejects the insurer's or health organization's challenge.

1314 (5) In the event of a notification by the commissioner to an insurer or health  
1315 organization that the insurer's or health organization's RBC plan or revised RBC plan is  
1316 unsatisfactory, the commissioner may specify in the notification that the notification constitutes  
1317 a regulatory action level event subject to the insurer's or health organization's right to a hearing  
1318 under Section [31A-17-607](#).

1319 (6) Every domestic insurer or health organization that files an RBC plan or revised  
1320 RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with  
1321 the insurance commissioner in any state in which the insurer or health organization is  
1322 authorized to do business if:

1323 (a) the state has an RBC provision substantially similar to Subsection [31A-17-608\(1\)](#);  
1324 and

1325 (b) the insurance commissioner of that state notifies the insurer or health organization  
1326 of its request for the filing in writing, in which case the insurer or health organization shall file  
1327 a copy of the RBC plan or revised RBC plan in that state no later than the later of:

1328 (i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan  
1329 with that state; or

1330 (ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3)  
1331 and (4).

1332 Section 21. Section **31A-22-505** is amended to read:

1333 **31A-22-505. Association groups.**

1334 (1) A policy is subject to the requirements of this section if the policy is issued as  
1335 policyholder to an association or to the trustees of a fund established, created, or maintained for  
1336 the benefit of members of one or more associations;

1337 (a) with a minimum membership of 100 persons~~[,]~~;

1338 (b) with a constitution and bylaws~~[, and which]~~;

1339 (c) having a shared or common purpose that is not primarily a business or customer  
1340 relationship; and

1341 (d) that has been in active existence for at least two years~~[, is subject to the following~~  
1342 ~~requirements:]~~.

1343 ~~[(+)]~~ (2) The policy may insure members and employees of the association, employees  
1344 of the members, one or more of the preceding entities, or all of any classes of these named  
1345 entities for the benefit of persons other than the employees' employer, or any officials,  
1346 representatives, trustees, or agents of the employer or association.

1347 ~~[(2)]~~ (3) The premiums shall be paid by the policyholder from funds contributed by the  
1348 associations, by employer members, from funds contributed by the covered persons, or from  
1349 any combination of these. Except as provided under Section **31A-22-512**, a policy on which no  
1350 part of the premium is contributed by the covered persons, specifically for their insurance, is  
1351 required to insure all eligible persons.

1352 Section 22. Section **31A-22-605** is amended to read:

1353 **31A-22-605. Accident and health insurance standards.**

1354 (1) The purposes of this section include:

1355 (a) reasonable standardization and simplification of terms and coverages of individual  
1356 and franchise accident and health insurance policies, including accident and health insurance  
1357 contracts of insurers licensed under Chapter 7, Nonprofit Health Service Insurance  
1358 Corporations, and Chapter 8, Health Maintenance Organizations and Limited Health Plans, to

1359 facilitate public understanding and comparison in purchasing;

1360 (b) elimination of provisions contained in individual and franchise accident and health  
1361 insurance contracts that may be misleading or confusing in connection with either the purchase  
1362 of those types of coverages or the settlement of claims; and

1363 (c) full disclosure in the sale of individual and franchise accident and health insurance  
1364 contracts.

1365 (2) As used in this section:

1366 (a) "Direct response insurance policy" means an individual insurance policy solicited  
1367 and sold without the policyholder having direct contact with a natural person intermediary.

1368 (b) "Medicare" means the same as that term is defined in Subsection 31A-22-620(1)(e).

1369 (c) "Medicare supplement policy" means the same as that term is defined in Subsection  
1370 31A-22-620(1)(f).

1371 (3) This section applies to all individual and franchise accident and health policies.

1372 (4) The commissioner shall adopt rules, made in accordance with Title 63G, Chapter 3,  
1373 Utah Administrative Rulemaking Act, relating to the following matters:

1374 (a) standards for the manner and content of policy provisions, and disclosures to be  
1375 made in connection with the sale of policies covered by this section, dealing with at least the  
1376 following matters:

1377 (i) terms of renewability;

1378 (ii) initial and subsequent conditions of eligibility;

1379 (iii) nonduplication of coverage provisions;

1380 (iv) coverage of dependents;

1381 (v) preexisting conditions;

1382 (vi) termination of insurance;

1383 (vii) probationary periods;

1384 (viii) limitations;

1385 (ix) exceptions;

1386 (x) reductions;

1387 (xi) elimination periods;

1388 (xii) requirements for replacement;

1389 (xiii) recurrent conditions;

- 1390 (xiv) coverage of persons eligible for Medicare; and  
1391 (xv) definition of terms;  
1392 (b) minimum standards for benefits under each of the following categories of coverage  
1393 in policies covered in this section:  
1394 (i) basic hospital expense coverage;  
1395 (ii) basic medical-surgical expense coverage;  
1396 (iii) hospital confinement indemnity coverage;  
1397 (iv) major medical expense coverage;  
1398 (v) income replacement coverage;  
1399 (vi) accident only coverage;  
1400 (vii) specified disease or specified accident coverage;  
1401 (viii) limited benefit health coverage; and  
1402 (ix) nursing home and long-term care coverage;  
1403 (c) the content and format of the outline of coverage, in addition to that required under  
1404 Subsection (6);  
1405 (d) the method of identification of policies and contracts based upon coverages  
1406 provided; and  
1407 (e) rating practices.  
1408 (5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine  
1409 categories of coverage in ~~[that subsection]~~ Subsection (4)(b) provided that any combination of  
1410 categories meets the standards of a component category of coverage.  
1411 (6) The commissioner may adopt rules, made in accordance with Title 63G, Chapter 3,  
1412 Utah Administrative Rulemaking Act, relating to the following matters:  
1413 (a) establishing disclosure requirements for insurance policies covered in this section,  
1414 designed to adequately inform the prospective insured of the need for and extent of the  
1415 coverage offered, and requiring that this disclosure be furnished to the prospective insured with  
1416 the application form, unless it is a direct response insurance policy;  
1417 (b) (i) prescribing caption or notice requirements designed to inform prospective  
1418 insureds that particular insurance coverages are not Medicare Supplement coverages;  
1419 (ii) the requirements of Subsection (6)(b)(i) apply to all insurance policies and  
1420 certificates sold to persons eligible for Medicare; and

1421 (c) requiring the disclosures or information brochures to be furnished to the  
1422 prospective insured on direct response insurance policies, upon his request or, in any event, no  
1423 later than the time of the policy delivery.

1424 (7) A policy covered by this section may be issued only if it meets the minimum  
1425 standards established by the commissioner under Subsection (4), an outline of coverage  
1426 accompanies the policy or is delivered to the applicant at the time of the application, and,  
1427 except with respect to direct response insurance policies, an acknowledged receipt is provided  
1428 to the insurer. The outline of coverage shall include:

1429 (a) a statement identifying the applicable categories of coverage provided by the policy  
1430 as prescribed under Subsection (4);

1431 (b) a description of the principal benefits and coverage;

1432 (c) a statement of the exceptions, reductions, and limitations contained in the policy;

1433 (d) a statement of the renewal provisions, including any reservation by the insurer of a  
1434 right to change premiums;

1435 (e) a statement that the outline is a summary of the policy issued or applied for and that  
1436 the policy should be consulted to determine governing contractual provisions; and

1437 (f) any other contents the commissioner prescribes.

1438 (8) If a policy is issued on a basis other than that applied for, the outline of coverage  
1439 shall accompany the policy when it is delivered and it shall clearly state that it is not the policy  
1440 for which application was made.

1441 (9) (a) Notwithstanding Subsection [31A-22-606\(1\)](#), limited accident and health  
1442 policies or certificates issued to persons eligible for Medicare shall contain a notice  
1443 prominently printed on or attached to the cover or front page which states that the policyholder  
1444 or certificate holder has the right to return the policy for any reason within 30 days after its  
1445 delivery and to have the premium refunded.

1446 (b) This Subsection (9) does not apply to a policy issued to an employer group.

1447 Section 23. Section [31A-22-610.5](#) is amended to read:

1448 **[31A-22-610.5. Dependent coverage.](#)**

1449 (1) As used in this section, "child" has the same meaning as defined in Section  
1450 [78B-12-102](#).

1451 (2) (a) Any individual or group accident and health insurance policy or health

1452 maintenance organization contract that provides coverage for a policyholder's or certificate  
1453 holder's dependent may not terminate coverage of an unmarried dependent by reason of the  
1454 dependent's age before the dependent's 26th birthday and shall, upon application, provide  
1455 coverage for all unmarried dependents up to age 26.

1456 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be  
1457 included in the premium on the same basis as other dependent coverage.

1458 (c) This section does not prohibit the employer from requiring the employee to pay all  
1459 or part of the cost of coverage for unmarried dependents.

1460 (d) An individual health insurance policy, group health insurance policy, or health  
1461 maintenance organization shall continue in force coverage for a dependent through the last day  
1462 of the month in which the dependent ceases to be a dependent:

1463 (i) if premiums are paid; and

1464 (ii) notwithstanding Section [31A-8-402.3](#), [31A-8-402.5](#), [31A-22-721](#), [31A-30-107.1](#),  
1465 or [31A-30-107.3](#).

1466 (3) An individual or group accident and health insurance policy or health maintenance  
1467 organization contract shall reinstate dependent coverage, and for purposes of all exclusions and  
1468 limitations, shall treat the dependent as if the coverage had been in force since it was  
1469 terminated; if:

1470 (a) the dependent has not reached the age of 26 by July 1, 1995;

1471 (b) the dependent had coverage prior to July 1, 1994;

1472 (c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age  
1473 of the dependent; and

1474 (d) the policy has not been terminated since the dependent's coverage was terminated.

1475 (4) (a) When a parent is required by a court or administrative order to provide health  
1476 insurance coverage for a child, an accident and health insurer may not deny enrollment of a  
1477 child under the accident and health insurance plan of the child's parent on the grounds the  
1478 child:

1479 (i) was born out of wedlock and is entitled to coverage under Subsection (5);

1480 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child  
1481 under the custodial parent's policy;

1482 (iii) is not claimed as a dependent on the parent's federal tax return; or



1483 (iv) does not reside with the parent or in the insurer's service area.

1484 (b) A child enrolled as required under Subsection (4)(a)(iv) is subject to the terms of  
1485 the accident and health insurance plan contract pertaining to services received outside of an  
1486 insurer's service area. A health maintenance organization shall comply with Section  
1487 [31A-8-502](#).

1488 (5) When a child has accident and health coverage through an insurer of a noncustodial  
1489 parent, and when requested by the noncustodial or custodial parent, the insurer shall:

1490 (a) provide information to the custodial parent as necessary for the child to obtain  
1491 benefits through that coverage, but the insurer or employer, or the agents or employees of either  
1492 of them, are not civilly or criminally liable for providing information in compliance with this  
1493 Subsection (5)(a), whether the information is provided pursuant to a verbal or written request;

1494 (b) permit the custodial parent or the service provider, with the custodial parent's  
1495 approval, to submit claims for covered services without the approval of the noncustodial  
1496 parent; and

1497 (c) make payments on claims submitted in accordance with Subsection (5)(b) directly  
1498 to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid  
1499 agency.

1500 (6) When a parent is required by a court or administrative order to provide health  
1501 coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

1502 (a) permit the parent to enroll, under the family coverage, a child who is otherwise  
1503 eligible for the coverage without regard to an enrollment season restrictions;

1504 (b) if the parent is enrolled but fails to make application to obtain coverage for the  
1505 child, enroll the child under family coverage upon application of the child's other parent, the  
1506 state agency administering the Medicaid program, or the state agency administering 42 U.S.C.  
1507 Sec. 651 through 669, the child support enforcement program; and

1508 (c) (i) when the child is covered by an individual policy, not disenroll or eliminate  
1509 coverage of the child unless the insurer is provided satisfactory written evidence that:

1510 (A) the court or administrative order is no longer in effect; or

1511 (B) the child is or will be enrolled in comparable accident and health coverage through  
1512 another insurer which will take effect not later than the effective date of disenrollment; or

1513 (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of

1514 the child unless the employer is provided with satisfactory written evidence, which evidence is  
1515 also provided to the insurer, that Subsection (9)(c)(i), (ii) or (iii) has happened.

1516 (7) An insurer may not impose requirements on a state agency that has been assigned  
1517 the rights of an individual eligible for medical assistance under Medicaid and covered for  
1518 accident and health benefits from the insurer that are different from requirements applicable to  
1519 an agent or assignee of any other individual so covered.

1520 (8) Insurers may not reduce their coverage of pediatric vaccines below the benefit level  
1521 in effect on May 1, 1993.

1522 (9) When a parent is required by a court or administrative order to provide health  
1523 coverage, which is available through an employer doing business in this state, the employer  
1524 shall:

1525 (a) permit the parent to enroll under family coverage any child who is otherwise  
1526 eligible for coverage without regard to any enrollment season restrictions;

1527 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,  
1528 enroll the child under family coverage upon application by the child's other parent, by the state  
1529 agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec.  
1530 651 through 669, the child support enforcement program;

1531 (c) not disenroll or eliminate coverage of the child unless the employer is provided  
1532 satisfactory written evidence that:

1533 (i) the court order is no longer in effect;

1534 (ii) the child is or will be enrolled in comparable coverage which will take effect no  
1535 later than the effective date of disenrollment; or

1536 (iii) the employer has eliminated family health coverage for all of its employees; and

1537 (d) withhold from the employee's compensation the employee's share, if any, of  
1538 premiums for health coverage and to pay this amount to the insurer.

1539 (10) An order issued under Section [62A-11-326.1](#) may be considered a "qualified  
1540 medical support order" for the purpose of enrolling a dependent child in a group accident and  
1541 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income  
1542 Security Act of 1974.

1543 (11) This section does not affect any insurer's ability to require as a precondition of any  
1544 child being covered under any policy of insurance that:

- 1545 (a) the parent continues to be eligible for coverage;
- 1546 (b) the child shall be identified to the insurer with adequate information to comply with  
1547 this section; and
- 1548 (c) the premium shall be paid when due.
- 1549 (12) [~~The provisions of this section apply~~] This section applies to employee welfare  
1550 benefit plans as defined in Section 26-19-2.
- 1551 [~~(13) The commissioner shall adopt rules interpreting and implementing this section  
1552 with regard to out-of-area court ordered dependent coverage.~~]
- 1553 (13) (a) A policy that provides coverage to a child of a group member may not deny  
1554 eligibility for coverage to a child solely because:
- 1555 (i) the child does not reside with the insured; or
- 1556 (ii) the child is solely dependent on a former spouse of the insured rather than on the  
1557 insured.
- 1558 (b) A child who does not reside with the insured may be excluded on the same basis as  
1559 a child who resides with the insured.

1560 Section 24. Section 31A-22-614.5 is amended to read:

1561 **31A-22-614.5. Uniform claims processing -- Electronic exchange of health  
1562 information.**

- 1563 (1) (a) Except as provided in Subsection (1)(c), [~~all insurers~~] an insurer offering health  
1564 insurance shall use a uniform claim form and uniform billing and claim codes.
- 1565 (b) Beginning January 1, 2011, all health benefit plans, and dental and vision plans,  
1566 shall provide for the electronic exchange of uniform:
- 1567 (i) eligibility and coverage information; and
- 1568 (ii) coordination of benefits information.
- 1569 (c) For purposes of Subsection (1)(a), "health insurance" does not include a policy or  
1570 certificate that provides benefits solely for:
- 1571 (i) income replacement; or
- 1572 (ii) long-term care.
- 1573 (2) (a) The uniform electronic standards and information required in Subsection (1)  
1574 shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3,  
1575 Utah Administrative Rulemaking Act.

1576 (b) When adopting rules under this section the commissioner:  
1577 (i) shall:  
1578 (A) consult with national and state organizations involved with the standardized  
1579 exchange of health data, and the electronic exchange of health data, to develop the standards  
1580 for the use and electronic exchange of uniform:  
1581 (I) claim forms;  
1582 (II) billing and claim codes;  
1583 (III) insurance eligibility and coverage information; and  
1584 (IV) coordination of benefits information; and  
1585 (B) meet federal mandatory minimum standards following the adoption of national  
1586 requirements for transaction and data elements in the federal Health Insurance Portability and  
1587 Accountability Act;  
1588 (ii) may not require an insurer or administrator to use a specific software product or  
1589 vendor; and  
1590 (iii) may require an insurer who participates in the all payer database created under  
1591 Section [26-33a-106.1](#) to allow data regarding demographic and insurance coverage information  
1592 to be electronically shared with the state's designated secure health information master person  
1593 index to be used:  
1594 (A) in compliance with data security standards established by:  
1595 (I) the federal Health Insurance Portability and Accountability Act; and  
1596 (II) the electronic commerce agreements established in a business associate agreement;  
1597 and  
1598 (B) for the purpose of coordination of health benefit plans.  
1599 (3) (a) The commissioner shall coordinate the administrative rules adopted under the  
1600 provisions of this section with the administrative rules adopted by the Department of Health for  
1601 the implementation of the standards for the electronic exchange of clinical health information  
1602 under Section [26-1-37](#). The department shall establish procedures for developing the rules  
1603 adopted under this section, which ensure that the Department of Health is given the opportunity  
1604 to comment on proposed rules.  
1605 (b) (i) The commissioner may provide information to health care providers regarding  
1606 resources available to a health care provider to verify whether a health care provider's practice

1607 management software system meets the uniform electronic standards for data exchange  
1608 required by this section.

1609 (ii) The commissioner may provide the information described in Subsection (3)(b)(i)  
1610 by partnering with:

1611 (A) a not-for-profit, broad based coalition of state health care insurers and health care  
1612 providers who are involved in the electronic exchange of the data required by this section; or

1613 (B) some other person that the commissioner determines is appropriate to provide the  
1614 information described in Subsection (3)(b)(i).

1615 (c) The commissioner shall regulate any fees charged by insurers to the providers for:

1616 (i) uniform claim forms;

1617 (ii) electronic billing; or

1618 (iii) the electronic exchange of clinical health information permitted by Section  
1619 26-1-37.

1620 (4) This section does not require a person to provide information concerning an  
1621 employer self-insured employee welfare benefit plan as defined in 29 U.S.C. Sec. 1002(1).

1622 Section 25. Section 31A-22-617 is amended to read:

1623 **31A-22-617. Preferred provider contract provisions.**

1624 Health insurance policies may provide for insureds to receive services or  
1625 reimbursement under the policies in accordance with preferred health care provider contracts as  
1626 follows:

1627 (1) Subject to restrictions under this section, an insurer or third party administrator may  
1628 enter into contracts with health care providers as defined in Section 78B-3-403 under which the  
1629 health care providers agree to supply services, at prices specified in the contracts, to persons  
1630 insured by an insurer.

1631 (a) (i) A health care provider contract may require the health care provider to accept the  
1632 specified payment in this Subsection (1) as payment in full, relinquishing the right to collect  
1633 additional amounts from the insured person.

1634 (ii) In a dispute involving a provider's claim for reimbursement, the same shall be  
1635 determined in accordance with applicable law, the provider contract, the subscriber contract,  
1636 and the insurer's written payment policies in effect at the time services were rendered.

1637 (iii) If the parties are unable to resolve their dispute, the matter shall be subject to

1638 binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except  
1639 the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii)  
1640 does not apply to the claim of a general acute hospital to the extent it is inconsistent with the  
1641 hospital's provider agreement.

1642 (iv) An organization may not penalize a provider solely for pursuing a claims dispute  
1643 or otherwise demanding payment for a sum believed owing.

1644 (v) If an insurer permits another entity with which it does not share common ownership  
1645 or control to use or otherwise lease one or more of the organization's networks of participating  
1646 providers, the organization shall ensure, at a minimum, that the entity pays participating  
1647 providers in accordance with the same fee schedule and general payment policies as the  
1648 organization would for that network.

1649 (b) The insurance contract may reward the insured for selection of preferred health care  
1650 providers by:

- 1651 (i) reducing premium rates;
- 1652 (ii) reducing deductibles;
- 1653 (iii) coinsurance;
- 1654 (iv) other copayments; or
- 1655 (v) any other reasonable manner.

1656 (c) If the insurer is a managed care organization, as defined in Subsection  
1657 [31A-27a-403\(1\)\(f\)](#):

1658 (i) the insurance contract and the health care provider contract shall provide that in the  
1659 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

1660 (A) require the health care provider to continue to provide health care services under  
1661 the contract until the earlier of:

1662 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for  
1663 liquidation; or

1664 (II) the date the term of the contract ends; and

1665 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to  
1666 receive from the managed care organization during the time period described in Subsection  
1667 (1)(c)(i)(A);

1668 (ii) the provider is required to:

- 1669 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and  
1670 (B) relinquish the right to collect additional amounts from the insolvent managed care  
1671 organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);
- 1672 (iii) if the contract between the health care provider and the managed care organization  
1673 has not been reduced to writing, or the contract fails to contain the requirements described in  
1674 Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:
- 1675 (A) sums owed by the insolvent managed care organization; or  
1676 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
- 1677 (iv) the following may not bill or maintain an action at law against an enrollee to  
1678 collect sums owed by the insolvent managed care organization or the amount of the regular fee  
1679 reduction authorized under Subsection (1)(c)(i)(B):
- 1680 (A) a provider;  
1681 (B) an agent;  
1682 (C) a trustee; or  
1683 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and  
1684 (v) notwithstanding Subsection (1)(c)(i):
- 1685 (A) a rehabilitator or liquidator may not reduce a fee ~~by~~ to less than 75% of the  
1686 provider's regular fee set forth in the contract; and
- 1687 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments  
1688 for services received from the provider that the enrollee was required to pay before the filing  
1689 of:
- 1690 (I) a petition for rehabilitation; or  
1691 (II) a petition for liquidation.
- 1692 (2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health  
1693 care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on  
1694 or after January 1, 2014.
- 1695 (b) When reimbursing for services of health care providers not under contract, the  
1696 insurer may make direct payment to the insured.
- 1697 (c) An insurer using preferred health care provider contracts may impose a deductible  
1698 on coverage of health care providers not under contract.
- 1699 (d) When selecting health care providers with whom to contract under Subsection (1),

1700 an insurer may not unfairly discriminate between classes of health care providers, but may  
1701 discriminate within a class of health care providers, subject to Subsection (7).

1702 (e) For purposes of this section, unfair discrimination between classes of health care  
1703 providers includes:

1704 (i) refusal to contract with class members in reasonable proportion to the number of  
1705 insureds covered by the insurer and the expected demand for services from class members; and

1706 (ii) refusal to cover procedures for one class of providers that are:

1707 (A) commonly used by members of the class of health care providers for the treatment  
1708 of illnesses, injuries, or conditions;

1709 (B) otherwise covered by the insurer; and

1710 (C) within the scope of practice of the class of health care providers.

1711 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose  
1712 to the insured that it has entered into preferred health care provider contracts. The insurer shall  
1713 provide sufficient detail on the preferred health care provider contracts to permit the insured to  
1714 agree to the terms of the insurance contract. The insurer shall provide at least the following  
1715 information:

1716 (a) a list of the health care providers under contract, and if requested their business  
1717 locations and specialties;

1718 (b) a description of the insured benefits, including deductibles, coinsurance, or other  
1719 copayments;

1720 (c) a description of the quality assurance program required under Subsection (4); and

1721 (d) a description of the adverse benefit determination procedures required under  
1722 Subsection (5).

1723 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality  
1724 assurance program for assuring that the care provided by the health care providers under  
1725 contract meets prevailing standards in the state.

1726 (b) The commissioner in consultation with the executive director of the Department of  
1727 Health may designate qualified persons to perform an audit of the quality assurance program.

1728 The auditors shall have full access to all records of the organization and its health care  
1729 providers, including medical records of individual patients.

1730 (c) The information contained in the medical records of individual patients shall



1731 remain confidential. All information, interviews, reports, statements, memoranda, or other data  
1732 furnished for purposes of the audit and any findings or conclusions of the auditors are  
1733 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal  
1734 proceeding except hearings before the commissioner concerning alleged violations of this  
1735 section.

1736 (5) An insurer using preferred health care provider contracts shall provide a reasonable  
1737 procedure for resolving complaints and adverse benefit determinations initiated by the insureds  
1738 and health care providers.

1739 (6) An insurer may not contract with a health care provider for treatment of illness or  
1740 injury unless the health care provider is licensed to perform that treatment.

1741 (7) (a) A health care provider or insurer may not discriminate against a preferred health  
1742 care provider for agreeing to a contract under Subsection (1).

1743 (b) A health care provider licensed to treat an illness or injury within the scope of the  
1744 health care provider's practice, who is willing and able to meet the terms and conditions  
1745 established by the insurer for designation as a preferred health care provider, shall be able to  
1746 apply for and receive the designation as a preferred health care provider. Contract terms and  
1747 conditions may include reasonable limitations on the number of designated preferred health  
1748 care providers based upon substantial objective and economic grounds, or expected use of  
1749 particular services based upon prior provider-patient profiles.

1750 (8) Upon the written request of a provider excluded from a provider contract, the  
1751 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is  
1752 based on the criteria set forth in Subsection (7)(b).

1753 (9) Nothing in this section is to be construed as to require an insurer to offer a certain  
1754 benefit or service as part of a health benefit plan.

1755 (10) This section does not apply to catastrophic mental health coverage provided in  
1756 accordance with Section [31A-22-625](#).

1757 (11) Notwithstanding Subsection (1), Subsection (7)(b), and Section [31A-22-618](#), an  
1758 insurer or third party administrator is not required to, but may, enter into a contract with a  
1759 licensed athletic trainer, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

1760 Section 26. Section [31A-22-645](#) is enacted to read:

1761 **[31A-22-645](#). Alcohol and drug dependency treatment.**

1762           (1) An insurer offering a health benefit plan providing coverage for alcohol or drug  
1763 dependency treatment may require an inpatient facility to be licensed by:

1764           (a) (i) the Department of Human Services, under Title 62A, Chapter 2, Licensure of  
1765 Programs and Facilities; or

1766           (ii) the Department of Health; or

1767           (b) for an inpatient facility located outside the state, a state agency similar to one  
1768 described in Subsection (1)(a).

1769           (2) For inpatient coverage provided pursuant to Subsection (1), an insurer may require  
1770 an inpatient facility to be accredited by the following:

1771           (a) the Joint Commission; and

1772           (b) one other nationally recognized accrediting agency.

1773           Section 27. Section **31A-22-701** is amended to read:

1774           **31A-22-701. Groups eligible for group or blanket insurance.**

1775           (1) As used in this section, "association group" means a lawfully formed association of  
1776 individuals or business entities that:

1777           (a) purchases insurance on a group basis on behalf of members; and

1778           (b) is formed and maintained in good faith for purposes other than obtaining insurance.

1779           (2) A group accident and health insurance policy may be issued to:

1780           (a) a group:

1781           (i) to which a group life insurance policy may be issued under Sections [31A-22-502](#),  
1782 [31A-22-503](#), [31A-22-504](#), [31A-22-506](#), [31A-22-507](#), and [31A-22-509](#); and

1783           (ii) that is formed and maintained in good faith for a purpose other than obtaining  
1784 insurance;

1785           (b) an association group that:

1786           (i) has been actively in existence for at least five years;

1787           (ii) has a constitution and bylaws;

1788           (iii) has a shared or common purpose that is not primarily a business or customer  
1789 relationship;

1790           ~~[(iii)]~~ (iv) is formed and maintained in good faith for purposes other than obtaining  
1791 insurance;

1792           ~~[(iv)]~~ (v) does not condition membership in the association group on any health

1793 status-related factor relating to an individual, including an employee of an employer or a  
1794 dependent of an employee;

1795 ~~[(v)]~~ (vi) makes accident and health insurance coverage offered through the association  
1796 group available to all members regardless of any health status-related factor relating to the  
1797 members or individuals eligible for coverage through a member;

1798 ~~[(vi)]~~ (vii) does not make accident and health insurance coverage offered through the  
1799 association group available other than in connection with a member of the association group;  
1800 and

1801 ~~[(vii)]~~ (viii) is actuarially sound; or

1802 (c) a group specifically authorized by the commissioner under Section 31A-22-509,  
1803 upon a finding that:

1804 (i) authorization is not contrary to the public interest;

1805 (ii) the group is actuarially sound;

1806 (iii) formation of the proposed group may result in economies of scale in acquisition,  
1807 administrative, marketing, and brokerage costs;

1808 (iv) the insurance policy, insurance certificate, or other indicia of coverage that will be  
1809 offered to the proposed group is substantially equivalent to insurance policies that are  
1810 otherwise available to similar groups;

1811 (v) the group would not present hazards of adverse selection;

1812 (vi) the premiums for the insurance policy and any contributions by or on behalf of the  
1813 insured persons are reasonable in relation to the benefits provided; and

1814 (vii) the group is formed and maintained in good faith for a purpose other than  
1815 obtaining insurance.

1816 (3) A blanket accident and health insurance policy:

1817 (a) covers a defined class of persons;

1818 (b) may not be offered or underwritten on an individual basis;

1819 (c) shall cover only a group that is:

1820 (i) actuarially sound; and

1821 (ii) formed and maintained in good faith for a purpose other than obtaining insurance;

1822 and

1823 (d) may be issued only to:

1824 (i) a common carrier or an operator, owner, or lessee of a means of transportation, as  
1825 policyholder, covering persons who may become passengers as defined by reference to the  
1826 person's travel status;

1827 (ii) an employer, as policyholder, covering any group of employees, dependents, or  
1828 guests, as defined by reference to specified hazards incident to any activities of the  
1829 policyholder;

1830 (iii) an institution of learning, including a school district, a school jurisdictional unit, or  
1831 the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering  
1832 students, teachers, or employees;

1833 (iv) a religious, charitable, recreational, educational, or civic organization, or branch of  
1834 one of those organizations, as policyholder, covering a group of members or participants as  
1835 defined by reference to specified hazards incident to the activities sponsored or supervised by  
1836 the policyholder;

1837 (v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering  
1838 members, campers, employees, officials, or supervisors;

1839 (vi) a volunteer fire department, first aid, civil defense, or other similar volunteer  
1840 organization, as policyholder, covering a group of members or participants as defined by  
1841 reference to specified hazards incident to activities sponsored, supervised, or participated in by  
1842 the policyholder;

1843 (vii) a newspaper or other publisher, as policyholder, covering its carriers;

1844 (viii) an association, including a labor union, that has a constitution and bylaws and  
1845 that is organized in good faith for purposes other than that of obtaining insurance, as  
1846 policyholder, covering a group of members or participants as defined by reference to specified  
1847 hazards incident to the activities or operations sponsored or supervised by the policyholder; and

1848 (ix) any other class of risks that, in the judgment of the commissioner, may be properly  
1849 eligible for blanket accident and health insurance.

1850 (4) The judgment of the commissioner may be exercised on the basis of:

1851 (a) individual risks;

1852 (b) a class of risks; or

1853 (c) both Subsections (4)(a) and (b).

1854 Section 28. Section **31A-22-716** is amended to read:

1855           **31A-22-716. Required provision for notice of termination.**

1856           (1) [Every] A policy for group or blanket accident and health coverage issued or  
1857 renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30  
1858 days prior written notice of termination to each employee or group member and to notify each  
1859 employee or group member of the employee's or group member's rights to continue coverage  
1860 upon termination.

1861           (2) An insurer's monthly notice to the policyholder of premium payments due shall  
1862 include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers  
1863 shall provide a sample notice to the policyholder at least once a year.

1864           ~~[(3) For the purpose of compliance with federal law and the Health Insurance~~  
1865 ~~Portability and Accountability Act, all health benefit plans, health insurers, and student health~~  
1866 ~~plans shall provide a certificate of creditable coverage to each covered person upon the person's~~  
1867 ~~termination from the plan as soon as reasonably possible.]~~

1868           Section 29. Section **31A-22-721** is amended to read:

1869           **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**  
1870 **nonrenewal.**

1871           (1) Except as otherwise provided in this section, a health benefit plan for a plan  
1872 sponsor is renewable and continues in force:

- 1873           (a) with respect to all eligible employees and dependents; and  
1874           (b) at the option of the plan sponsor.

1875           (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed for a  
1876 network plan, if:

1877           (a) there is no longer any enrollee under the group health plan who lives, resides, or  
1878 works in:

- 1879           (i) the service area of the insurer; or  
1880           (ii) the area for which the insurer is authorized to do business; or

1881           (b) for coverage made available in the small or large employer market only through an  
1882 association, if:

- 1883           (i) the employer's membership in the association ceases; and  
1884           (ii) the coverage is terminated uniformly without regard to any health status-related  
1885 factor relating to any covered individual.

- 1886 (3) A health benefit plan for a plan sponsor may be discontinued if:
- 1887 (a) a condition described in Subsection (2) exists;
- 1888 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
- 1889 terms of the contract;
- 1890 (c) the plan sponsor:
- 1891 (i) performs an act or practice that constitutes fraud; or
- 1892 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 1893 coverage;
- 1894 (d) the insurer:
- 1895 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or
- 1896 issued for delivery in this state;
- 1897 (ii) (A) provides notice of the discontinuation in writing:
- 1898 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
- 1899 (II) at least 90 days before the date the coverage will be discontinued;
- 1900 (B) provides notice of the discontinuation in writing:
- 1901 (I) to the commissioner; and
- 1902 (II) at least three working days prior to the date the notice is sent to the affected plan
- 1903 sponsors, employees, and dependents of plan sponsors or employees;
- 1904 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
- 1905 other health benefit [~~products~~] plans currently being offered:
- 1906 (I) by the insurer in the market; or
- 1907 (II) in the case of a large employer, any other health benefit plan currently being
- 1908 offered in that market; and
- 1909 (D) in exercising the option to discontinue that [~~product~~] health benefit plan and in
- 1910 offering the option of coverage in this section, the insurer acts uniformly without regard to:
- 1911 (I) the claims experience of a plan sponsor;
- 1912 (II) any health status-related factor relating to any covered participant or beneficiary; or
- 1913 (III) any health status-related factor relating to a new participant or beneficiary who
- 1914 may become eligible for coverage; or
- 1915 (e) the insurer:
- 1916 (i) elects to discontinue all of the insurer's health benefit plans:

- 1917 (A) in the small employer market; or  
1918 (B) the large employer market; or  
1919 (C) both the small and large employer markets; and  
1920 (ii) (A) provides notice of the discontinuance in writing:  
1921 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and  
1922 (II) at least 180 days before the date the coverage will be discontinued;  
1923 (B) provides notice of the discontinuation in writing:  
1924 (I) to the commissioner in each state in which an affected insured individual is known  
1925 to reside; and  
1926 (II) at least 30 business days prior to the date the notice is sent to the affected plan  
1927 sponsors, employees, and dependents of a plan sponsor or employee;  
1928 (C) discontinues and nonrenews all plans issued or delivered for issuance in the  
1929 market; and  
1930 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).  
1931 (4) A large employer health benefit plan may be discontinued or nonrenewed:  
1932 (a) if a condition described in Subsection (2) exists; or  
1933 (b) for noncompliance with the insurer's:  
1934 (i) minimum participation requirements; or  
1935 (ii) employer contribution requirements.  
1936 (5) A small employer health benefit plan may be discontinued or nonrenewed:  
1937 (a) if a condition described in Subsection (2) exists; or  
1938 (b) for noncompliance with the insurer's employer contribution requirements.  
1939 (6) A small employer health benefit plan may be nonrenewed:  
1940 (a) if a condition described in Subsection (2) exists; or  
1941 (b) for noncompliance with the insurer's minimum participation requirements.  
1942 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be  
1943 discontinued if after issuance of coverage the eligible employee:  
1944 (i) engages in an act or practice that constitutes fraud in connection with the coverage;  
1945 or  
1946 (ii) makes an intentional misrepresentation of material fact in connection with the  
1947 coverage.

1948 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:  
1949 (i) 12 months after the date of discontinuance; and  
1950 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies  
1951 to reenroll.

1952 (c) At the time the eligible employee's coverage is discontinued under Subsection  
1953 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is  
1954 discontinued.

1955 (d) An eligible employee may not be discontinued under this Subsection (7) because of  
1956 a fraud or misrepresentation that relates to health status.

1957 (8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue  
1958 offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new  
1959 business in such market in this state for a period of five years beginning on the date of  
1960 discontinuation of the last coverage that is discontinued.

1961 (b) The commissioner may waive the prohibition under Subsection (8)(a) when the  
1962 commissioner finds that waiver is in the public interest:

- 1963 (i) to promote competition; or
- 1964 (ii) to resolve inequity in the marketplace.

1965 (9) If an insurer is doing business in one established geographic service area of the  
1966 state, this section applies only to the insurer's operations in that geographic service area.

1967 (10) An insurer may modify a health benefit plan for a plan sponsor only:

- 1968 (a) at the time of coverage renewal; and
- 1969 (b) if the modification is effective uniformly among all plans with a particular product  
1970 or service.

1971 (11) For purposes of this section, a reference to "plan sponsor" includes a reference to  
1972 the employer:

1973 (a) with respect to coverage provided to an employer member of the association; and

1974 (b) if the health benefit plan is made available by an insurer in the employer market  
1975 only through:

- 1976 (i) an association;
- 1977 (ii) a trust; or
- 1978 (iii) a discretionary group.



1979 (12) (a) A small employer that, after purchasing a health benefit plan in the small group  
1980 market, employs on average more than 50 eligible employees on each business day in a  
1981 calendar year may continue to renew the health benefit plan purchased in the small group  
1982 market.

1983 (b) A large employer that, after purchasing a health benefit plan in the large group  
1984 market, employs on average less than 51 eligible employees on each business day in a calendar  
1985 year may continue to renew the health benefit plan purchased in the large group market.

1986 (13) An insurer offering employer sponsored health benefit plans shall comply with the  
1987 Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.

1988 Section 30. Section **31A-22-801** is amended to read:

1989 **31A-22-801. Scope of part.**

1990 (1) Except as provided under Subsection (2), all life insurance and accident and health  
1991 insurance in connection with loans or other credit transactions are subject to this part.

1992 (2) (a) Insurance written in connection with a [~~loan or other~~] credit transaction [~~of more~~  
1993 ~~than 10 years duration~~] is not subject to this part, but is subject to other provisions of this  
1994 title[-], if the credit transaction is:

1995 (i) secured by a first mortgage or deed of trust; and

1996 (ii) made to finance the purchase of real property or the construction of a dwelling  
1997 thereon, or to refinance a prior credit transaction made for such a purpose.

1998 (b) Isolated transactions on the part of an insurer that are not related to an agreement or  
1999 plan for insuring debtors of the creditor are not subject to this part.

2000 Section 31. Section **31A-22-1902** is amended to read:

2001 **31A-22-1902. Definitions.**

2002 As used in this part:

2003 (1) "Administrator" means the same as that term is defined in Section [67-4a-102](#).

2004 (2) "Asymmetric conduct" means an insurer's use of the death master file or other  
2005 similar database before July 1, 2015, in connection with searching for information regarding  
2006 whether annuitants under the insurer's annuities might be deceased, but not in connection with  
2007 whether the insureds under the insurer's policies might be deceased.

2008 (3) (a) "Contract" means an annuity contract.

2009 (b) "Contract" does not include an annuity used to fund an employment-based

2010 retirement plan or program when:

2011 (i) the insurer does not perform the record keeping services; or

2012 (ii) the insurer is not committed by terms of the annuity contract to pay death benefits  
2013 to the beneficiaries of specific plan participants.

2014 (4) "Death master file" means the United States Social Security Administration's Death  
2015 Master File or another database or service that is at least as comprehensive as the United States  
2016 Social Security Administration's Death Master File for determining that a person has reportedly  
2017 died.

2018 (5) "Death master file match" means a search of a death master file that results in a  
2019 match of the Social Security number, or the name and date of birth of an insured, annuity  
2020 owner, or retained asset account holder.

2021 [~~(6) "Knowledge of death" means:~~]

2022 [~~(a) receipt of an original or valid copy of a certified death certificate; or]~~

2023 [~~(b) a death master file match validated by the insurer in accordance with Subsection~~  
2024 ~~31A-22-1903(1)(a).~~]

2025 [(7)] (6) (a) "Policy" means a policy or certificate of life insurance that provides a death  
2026 benefit.

2027 (b) "Policy" does not include:

2028 (i) a policy or certificate of life insurance that provides a death benefit under an  
2029 employee benefit plan:

2030 (A) subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec.  
2031 1002, as periodically amended; or

2032 (B) under ~~[any]~~ a federal employee benefit program;

2033 (ii) a policy or certificate of life insurance that is used to fund a preneed funeral  
2034 contract or prearrangement;

2035 (iii) a policy or certificate of credit life or accidental death insurance; or

2036 (iv) a policy issued to a group master policyholder for which the insurer does not  
2037 provide record keeping services.

2038 [(8)] (7) "Record keeping services" means those circumstances under which the insurer  
2039 agrees with a group policy or contract customer to be responsible for obtaining, maintaining,  
2040 and administering, in its own or its agents' systems, information about each individual insured

2041 under an insured's group insurance contract, or a line of coverage under the group insurance  
 2042 contract, at least the following information:

- 2043 (a) social security number, or name and date of birth;
- 2044 (b) beneficiary designation information;
- 2045 (c) coverage eligibility;
- 2046 (d) benefit amount; and
- 2047 (e) premium payment status.

2048 [~~(9)~~] (8) "Retained asset account" means [~~any~~] a mechanism whereby the settlement of  
 2049 proceeds payable under a policy or contract is accomplished by the insurer or an entity acting  
 2050 on behalf of the insurer by depositing the proceeds into an account with check or draft writing  
 2051 privileges, where those proceeds are retained by the insurer or its agent, pursuant to a  
 2052 supplementary contract not involving annuity benefits other than death benefits.

2053 Section 32. Section **31A-23a-111** is amended to read:

2054 **31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
 2055 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**

2056 (1) A license type issued under this chapter remains in force until:

- 2057 (a) revoked or suspended under Subsection (5);
- 2058 (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
 2059 administrative action;

2060 (c) the licensee dies or is adjudicated incompetent as defined under:

- 2061 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
- 2062 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
 2063 Minors;

2064 (d) lapsed under Section [31A-23a-113](#); or

2065 (e) voluntarily surrendered.

2066 (2) The following may be reinstated within one year after the day on which the license  
 2067 is no longer in force:

- 2068 (a) a lapsed license; or
- 2069 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
 2070 not be reinstated after the license period in which the license is voluntarily surrendered.

2071 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a

2072 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
2073 department from pursuing additional disciplinary or other action authorized under:

2074 (a) this title; or

2075 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah

2076 Administrative Rulemaking Act.

2077 (4) A line of authority issued under this chapter remains in force until:

2078 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;

2079 or

2080 (b) the supporting license type:

2081 (i) is revoked or suspended under Subsection (5);

2082 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of

2083 administrative action;

2084 (iii) lapses under Section 31A-23a-113; or

2085 (iv) is voluntarily surrendered; or

2086 (c) the licensee dies or is adjudicated incompetent as defined under:

2087 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

2088 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and

2089 Minors.

2090 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an

2091 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the

2092 commissioner may:

2093 (i) revoke:

2094 (A) a license; or

2095 (B) a line of authority;

2096 (ii) suspend for a specified period of 12 months or less:

2097 (A) a license; or

2098 (B) a line of authority;

2099 (iii) limit in whole or in part:

2100 (A) a license; or

2101 (B) a line of authority; [or]

2102 (iv) deny a license application[-];

- 2103 (v) assess a forfeiture under Subsection [31A-2-308\(1\)\(b\)\(i\)](#) or [\(1\)\(c\)\(i\)](#); or  
2104 (vi) take a combination of actions under Subsections [\(5\)\(a\)\(i\)](#) through [\(iv\)](#) and  
2105 Subsection [\(5\)\(a\)\(v\)](#).
- 2106 (b) The commissioner may take an action described in Subsection (5)(a) if the  
2107 commissioner finds that the licensee:
- 2108 (i) is unqualified for a license or line of authority under Section [31A-23a-104](#),  
2109 [31A-23a-105](#), or [31A-23a-107](#);
- 2110 (ii) violates:
- 2111 (A) an insurance statute;
- 2112 (B) a rule that is valid under Subsection [31A-2-201\(3\)](#); or
- 2113 (C) an order that is valid under Subsection [31A-2-201\(4\)](#);
- 2114 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other  
2115 delinquency proceedings in any state;
- 2116 (iv) fails to pay a final judgment rendered against the person in this state within 60  
2117 days after the day on which the judgment became final;
- 2118 (v) fails to meet the same good faith obligations in claims settlement that is required of  
2119 admitted insurers;
- 2120 (vi) is affiliated with and under the same general management or interlocking  
2121 directorate or ownership as another insurance producer that transacts business in this state  
2122 without a license;
- 2123 (vii) refuses:
- 2124 (A) to be examined; or
- 2125 (B) to produce its accounts, records, and files for examination;
- 2126 (viii) has an officer who refuses to:
- 2127 (A) give information with respect to the insurance producer's affairs; or
- 2128 (B) perform any other legal obligation as to an examination;
- 2129 (ix) provides information in the license application that is:
- 2130 (A) incorrect;
- 2131 (B) misleading;
- 2132 (C) incomplete; or
- 2133 (D) materially untrue;

- 2134 (x) violates an insurance law, valid rule, or valid order of another regulatory agency in  
2135 any jurisdiction;
- 2136 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
- 2137 (xii) improperly withholds, misappropriates, or converts money or properties received  
2138 in the course of doing insurance business;
- 2139 (xiii) intentionally misrepresents the terms of an actual or proposed:
  - 2140 (A) insurance contract;
  - 2141 (B) application for insurance; or
  - 2142 (C) life settlement;
- 2143 (xiv) is convicted of a felony;
- 2144 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
- 2145 (xvi) in the conduct of business in this state or elsewhere:
  - 2146 (A) uses fraudulent, coercive, or dishonest practices; or
  - 2147 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
- 2148 (xvii) has an insurance license, or its equivalent, denied, suspended, or revoked in  
2149 another state, province, district, or territory;
- 2150 (xviii) forges another's name to:
  - 2151 (A) an application for insurance; or
  - 2152 (B) a document related to an insurance transaction;
- 2153 (xix) improperly uses notes or another reference material to complete an examination  
2154 for an insurance license;
- 2155 (xx) knowingly accepts insurance business from an individual who is not licensed;
- 2156 (xxi) fails to comply with an administrative or court order imposing a child support  
2157 obligation;
- 2158 (xxii) fails to:
  - 2159 (A) pay state income tax; or
  - 2160 (B) comply with an administrative or court order directing payment of state income  
2161 tax;
- 2162 (xxiii) violates or permits others to violate the federal Violent Crime Control and Law  
2163 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is  
2164 prohibited from engaging in the business of insurance; or

2165 (xxiv) engages in a method or practice in the conduct of business that endangers the  
2166 legitimate interests of customers and the public.

2167 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
2168 and any individual designated under the license are considered to be the holders of the license.

2169 (d) If an individual designated under the agency license commits an act or fails to  
2170 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
2171 the commissioner may suspend, revoke, or limit the license of:

2172 (i) the individual;

2173 (ii) the agency, if the agency:

2174 (A) is reckless or negligent in its supervision of the individual; or

2175 (B) knowingly participates in the act or failure to act that is the ground for suspending,  
2176 revoking, or limiting the license; or

2177 (iii) (A) the individual; and

2178 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

2179 (6) A licensee under this chapter is subject to the penalties for acting as a licensee  
2180 without a license if:

2181 (a) the licensee's license is:

2182 (i) revoked;

2183 (ii) suspended;

2184 (iii) limited;

2185 (iv) surrendered in lieu of administrative action;

2186 (v) lapsed; or

2187 (vi) voluntarily surrendered; and

2188 (b) the licensee:

2189 (i) continues to act as a licensee; or

2190 (ii) violates the terms of the license limitation.

2191 (7) A licensee under this chapter shall immediately report to the commissioner:

2192 (a) a revocation, suspension, or limitation of the person's license in another state, the  
2193 District of Columbia, or a territory of the United States;

2194 (b) the imposition of a disciplinary sanction imposed on that person by another state,  
2195 the District of Columbia, or a territory of the United States; or

2196 (c) a judgment or injunction entered against that person on the basis of conduct  
2197 involving:

2198 (i) fraud;

2199 (ii) deceit;

2200 (iii) misrepresentation; or

2201 (iv) a violation of an insurance law or rule.

2202 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a  
2203 license in lieu of administrative action may specify a time, not to exceed five years, within  
2204 which the former licensee may not apply for a new license.

2205 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the  
2206 former licensee may not apply for a new license for five years from the day on which the order  
2207 or agreement is made without the express approval by the commissioner.

2208 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
2209 a license issued under this part if so ordered by a court.

2210 (10) The commissioner shall by rule prescribe the license renewal and reinstatement  
2211 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2212 Section 33. Section **31A-23a-115** is amended to read:

2213 **31A-23a-115. Appointment of individual and agency insurance producer, limited**  
2214 **line producer, or managing general agent -- Reports and lists.**

2215 (1) (a) An insurer shall appoint an individual or agency with whom it has a contract as  
2216 an insurance producer, limited line producer, or managing general agent to act on the insurer's  
2217 behalf in order for the licensee to do business for the insurer in this state.

2218 (b) An insurer shall report to the commissioner, at intervals and in the form the  
2219 commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah  
2220 Administrative Rulemaking Act:

2221 (i) a new appointment; and

2222 (ii) a termination of appointment.

2223 (2) An insurer shall notify a producer that the producer's appointment is terminated by  
2224 the insurer and of the reason for termination at an interval and in the form the commissioner  
2225 establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative  
2226 Rulemaking Act.



2227           ~~[(2)]~~ (3) (a) (i) An insurer shall report to the commissioner the cause of termination of  
 2228 an appointment if:

2229           (A) the reason for termination is a reason described in Subsection 31A-23a-111(5)(b);  
 2230 or

2231           (B) the insurer has knowledge that the individual or agency licensee is found to have  
 2232 engaged in an activity described in Subsection 31A-23a-111(5)(b) by:

2233           (I) a court;

2234           (II) a government body; or

2235           (III) a self-regulatory organization, which the commissioner may define by rule made  
 2236 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2237           (ii) The information provided to the commissioner under this Subsection ~~[(2)]~~ (3) is a  
 2238 private record under Title 63G, Chapter 2, Government Records Access and Management Act.

2239           (b) An insurer is immune from civil action, civil penalty, or damages if the insurer  
 2240 complies in good faith with this Subsection ~~[(2)]~~ (3) in reporting to the commissioner the cause  
 2241 of termination of an appointment.

2242           (c) Notwithstanding any other provision in this section, an insurer is not immune from  
 2243 any action or resulting penalty imposed on the reporting insurer as a result of proceedings  
 2244 brought by or on behalf of the department if the action is based on evidence other than the  
 2245 report submitted in compliance with this Subsection ~~[(2)]~~ (3).

2246           ~~[(3)]~~ (4) If an insurer appoints an agency, the insurer need not appoint, report, or pay  
 2247 appointment reporting fees for an individual designated on the agency's license under Section  
 2248 31A-23a-302.

2249           ~~[(4)]~~ (5) If an insurer contracts with or lists a licensee in a report submitted under  
 2250 Subsection ~~[(2)]~~ (3), there is a rebuttable presumption that in placing a risk with the insurer the  
 2251 contracted or appointed licensee or any of the licensee's licensed employees act on behalf of the  
 2252 insurer.

2253           Section 34. Section 31A-23a-203 is amended to read:

2254           **31A-23a-203. Training period requirements.**

2255           (1) A producer is eligible to become a surplus lines producer only if the producer:

2256           (a) has passed the applicable surplus lines producer examination;

2257           (b) has been a producer with property or casualty or both lines of authority for at least

2258 three years during the four years immediately preceding the date of application; and

2259 (c) has paid the applicable fee under Section 31A-3-103.

2260 (2) A person is eligible to become a consultant only if the person has acted in a  
2261 capacity that would provide the person with preparation to act as an insurance consultant for a  
2262 period aggregating not less than three years during the four years immediately preceding the  
2263 date of application.

2264 (3) (a) A resident producer with an accident and health line of authority may only sell  
2265 long-term care insurance if the producer:

2266 (i) initially completes a minimum of three hours of long-term care training before  
2267 selling long-term care coverage; and

2268 (ii) after completing the training required by Subsection (3)(a)(i), completes a  
2269 minimum of three hours of long-term care training during each subsequent two-year licensing  
2270 period.

2271 (b) A course taken to satisfy a long-term care training requirement may be used toward  
2272 satisfying a producer continuing education requirement.

2273 (c) Long-term care training is not a continuing education requirement to renew a  
2274 producer license.

2275 (d) An insurer that issues long-term care insurance shall demonstrate to the  
2276 commissioner, upon request, that a producer who is appointed by the insurer and who sells  
2277 long-term care insurance coverage is in compliance with this Subsection (3).

2278 (4) (a) A resident producer with a property line of authority may only sell flood  
2279 insurance coverage under the National Flood Insurance Program if the producer completes a  
2280 minimum of three hours of flood insurance training related to the National Flood Insurance  
2281 Program before selling flood insurance coverage.

2282 (b) A course taken to satisfy a flood insurance training requirement may be used  
2283 toward satisfying a producer continuing education requirement.

2284 (c) Flood insurance training is not a continuing education requirement to renew a  
2285 producer license.

2286 (d) An insurer that issues flood insurance shall demonstrate to the commissioner, upon  
2287 request, that a producer who is appointed by the insurer and who sells flood insurance coverage  
2288 is in compliance with this Subsection (4).

2289           ~~[(4)]~~ (5) The training periods required under this section apply only to an individual  
2290 applying for a license under this chapter.

2291           Section 35. Section **31A-23a-302** is amended to read:

2292           **31A-23a-302. Agency designations.**

2293           (1) An agency shall designate an individual that has an individual producer, surplus  
2294 lines producer, limited line producer, consultant, managing general agent, or reinsurance  
2295 intermediary license to act on the agency's behalf in order for the licensee to do business for the  
2296 agency in this state.

2297           (2) An agency shall report to the commissioner, at intervals and in the form the  
2298 commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah  
2299 Administrative Rulemaking Act:

2300           (a) a new designation; and

2301           (b) a terminated designation.

2302           (3) An agency shall notify an individual designee that the individual's designation is  
2303 terminated by the agency and of the reason for termination at an interval and in the form the  
2304 commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah  
2305 Administrative Rulemaking Act.

2306           ~~[(3)]~~ (4) (a) An agency licensed under this chapter shall report to the commissioner the  
2307 cause of termination of a designation if:

2308           (i) the reason for termination is a reason described in Subsection **31A-23a-111(5)(b)**;

2309 or

2310           (ii) the agency has knowledge that the individual licensee is found to have engaged in  
2311 an activity described in Subsection **31A-23a-111(5)(b)** by:

2312           (A) a court;

2313           (B) a government body; or

2314           (C) a self-regulatory organization, which the commissioner may define by rule made in  
2315 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2316           (b) The information provided the commissioner under Subsection ~~[(3)]~~ (4)(a) is a  
2317 private record under Title 63G, Chapter 2, Government Records Access and Management Act.

2318           (c) An agency is immune from civil action, civil penalty, or damages if the agency  
2319 complies in good faith with this Subsection ~~[(3)]~~ (4) in reporting to the commissioner the cause

2320 of termination of a designation.

2321 (d) Notwithstanding any other provision in this section, an agency is not immune from  
2322 an action or resulting penalty imposed on the reporting agency as a result of proceedings  
2323 brought by or on behalf of the department if the action is based on evidence other than the  
2324 report submitted in compliance with this Subsection [~~(3)~~] (4).

2325 [~~(4)~~] (5) An agency licensed under this chapter may act in a capacity for which it is  
2326 licensed only through an individual who is licensed under this chapter to act in the same  
2327 capacity.

2328 [~~(5)~~] (6) An agency licensed under this chapter shall designate and report to the  
2329 commissioner in accordance with any rule made by the commissioner in accordance with Title  
2330 63G, Chapter 3, Utah Administrative Rulemaking Act, the name of the designated responsible  
2331 licensed individual who has authority to act on behalf of the agency in the matters pertaining to  
2332 compliance with this title and orders of the commissioner.

2333 [~~(6)~~] (7) If an agency contracts with or designates a licensee in reports submitted under  
2334 Subsection (2) or [~~(5)~~] (6), there is a rebuttable presumption that the contracted or designated  
2335 licensee acts on behalf of the agency.

2336 [~~(7)~~] (8) (a) When a license is held by an agency, both the agency itself and any  
2337 individual contracted or designated under the agency license shall be considered to be the  
2338 holder of the agency license for purposes of this section.

2339 (b) If an individual contracted or designated under the agency license commits an act or  
2340 fails to perform a duty that is a ground for suspending, revoking, or limiting the agency license,  
2341 or assessing a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i), the commissioner  
2342 may assess a forfeiture, suspend, revoke, or limit the license of, or take a combination of these  
2343 actions against:

2344 (i) the individual;

2345 (ii) the agency, if the agency:

2346 (A) is reckless or negligent in its supervision of the individual; or

2347 (B) knowingly participates in the act or failure to act that is the ground for assessing a  
2348 forfeiture, or suspending, revoking, or limiting the license; or

2349 (iii) (A) the individual; and

2350 (B) the agency if the agency meets the requirements of Subsection [~~(7)~~] (8)(b)(ii).

2351 Section 36. Section **31A-23a-407** is amended to read:

2352 **31A-23a-407. Liability for acts of title insurance producers.**

2353 (1) Subject to the other provisions in this section, a title insurer that contracts with or  
2354 appoints an individual title insurance producer or an agency title insurance producer is liable to  
2355 a buyer, seller, borrower, lender, or third party that deposits money with the individual title  
2356 insurance producer or agency title insurance producer for the receipt and disbursement of  
2357 money deposited with the individual title insurance producer or agency title insurance producer  
2358 for a transaction when a commitment for a policy of title insurance of that title insurer is  
2359 ordered, issued, or distributed or a title insurance policy of that title insurer is issued, except  
2360 that once a title insurer is named in an issued commitment only that title insurer is liable as a  
2361 title insurer under this section.

2362 (2) The liability of a title insurer under Subsection (1) and the liability of an individual  
2363 title insurance producer or agency title insurance producer for the receipt and disbursement of  
2364 money deposited with the individual title insurance producer or agency title insurance producer  
2365 is limited to the amount of money received and disbursed, not to exceed the amount of  
2366 proposed insurance set forth in the commitment or title insurance policy described in  
2367 Subsection (1) plus 10% of the amount of the proposed insurance.

2368 (3) The liability described in Subsection (1) does not modify, mitigate, impair, or affect  
2369 the contractual obligations between an individual title insurance producer or agency title  
2370 insurance producer and the title insurer.

2371 (4) The liability of a title insurer with respect to the condition of title to the real  
2372 property that is the subject of a title insurance policy or a title insurance commitment for a title  
2373 insurance policy is limited to the terms, conditions, and stipulations contained in the title  
2374 insurance policy or title commitment.

2375 Section 37. Section **31A-23a-412** is amended to read:

2376 **31A-23a-412. Place of business and residence address -- Records.**

2377 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:

2378 (i) the address and the one or more telephone numbers of the licensee's principal place  
2379 of business; and

2380 (ii) a valid business email address at which the commissioner may contact the licensee.

2381 (b) If a licensee is an individual, in addition to complying with Subsection (1)(a) the

2382 individual shall register and maintain with the commissioner the individual's residence address  
2383 and telephone number.

2384 (c) A licensee shall notify the commissioner within 30 days of a change of any of the  
2385 following required to be registered with the commissioner under this section:

2386 (i) an address;

2387 (ii) a telephone number; or

2388 (iii) a business email address.

2389 (2) (a) Except as provided under Subsection (3), a licensee under this chapter or an  
2390 insurer under Chapter 14, Foreign Insurers, shall keep at the principal place of business address  
2391 registered under Subsection (1), separate and distinct books and records of the transactions  
2392 consummated under the Utah license.

2393 (b) The books and records described in Subsection (2)(a) shall:

2394 (i) be in an organized form;

2395 (ii) be available to the commissioner for inspection upon reasonable notice; and

2396 (iii) include all of the following:

2397 (A) if the licensee is a producer, surplus lines producer, limited line producer,  
2398 consultant, managing general agent, or reinsurance intermediary:

2399 (I) a record of each insurance contract procured by or issued through the licensee, with  
2400 the names of insurers and insureds, the amount of premium and commissions or other  
2401 compensation, and the subject of the insurance;

2402 (II) the names of any other producers, surplus lines producers, limited line producers,  
2403 consultants, managing general agents, or reinsurance intermediaries from whom business is  
2404 accepted, and of persons to whom commissions or allowances of any kind are promised or  
2405 paid; and

2406 (III) a record of the consumer complaints forwarded to the licensee by an insurance  
2407 regulator;

2408 (B) if the licensee is a consultant, a record of each agreement outlining the work  
2409 performed and the fee for the work; and

2410 (C) any additional information which:

2411 (I) is customary for a similar business; or

2412 (II) may reasonably be required by the commissioner by rule made in accordance with

2413 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2414 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can  
2415 be obtained immediately from a central storage place or elsewhere by on-line computer  
2416 terminals located at the registered address.

2417 (4) A licensee who represents only a single insurer satisfies Subsection (2) if the  
2418 insurer maintains the books and records pursuant to Subsection (2) at a place satisfying  
2419 Subsections (1) and (5).

2420 (5) (a) The books and records maintained under Subsection (2) or Section  
2421 [31A-23a-413](#) shall be available for the inspection of the commissioner during the business  
2422 hours for a period of time after the date of the transaction as specified by the commissioner by  
2423 rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, but  
2424 in no case for less than three calendar years in addition to the current calendar year [~~plus three~~  
2425 ~~years~~].

2426 (b) Discarding [~~books and records~~] a book or record after the applicable record  
2427 retention period has expired does not place the licensee in violation of a later-adopted longer  
2428 record retention period.

2429 Section 38. Section [31A-23a-501](#) is amended to read:

2430 **[31A-23a-501. Licensee compensation.](#)**

2431 (1) As used in this section:

2432 (a) "Commission compensation" includes funds paid to or credited for the benefit of a  
2433 licensee from:

2434 (i) commission amounts deducted from insurance premiums on insurance sold by or  
2435 placed through the licensee;

2436 (ii) commission amounts received from an insurer or another licensee as a result of the  
2437 sale or placement of insurance; or

2438 (iii) overrides, bonuses, contingent bonuses, or contingent commissions received from  
2439 an insurer or another licensee as a result of the sale or placement of insurance.

2440 (b) (i) "Compensation from an insurer or third party administrator" means  
2441 commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,  
2442 gifts, prizes, or any other form of valuable consideration:

2443 (A) whether or not payable pursuant to a written agreement; and

- 2444 (B) received from:
- 2445 (I) an insurer; or
- 2446 (II) a third party to the transaction for the sale or placement of insurance.
- 2447 (ii) "Compensation from an insurer or third party administrator" does not mean
- 2448 compensation from a customer that is:
- 2449 (A) a fee or pass-through costs as provided in Subsection (1)(e); or
- 2450 (B) a fee or amount collected by or paid to the producer that does not exceed an
- 2451 amount established by the commissioner by administrative rule.
- 2452 (c) (i) "Customer" means:
- 2453 (A) the person signing the application or submission for insurance; or
- 2454 (B) the authorized representative of the insured actually negotiating the placement of
- 2455 insurance with the producer.
- 2456 (ii) "Customer" does not mean a person who is a participant or beneficiary of:
- 2457 (A) an employee benefit plan; or
- 2458 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or
- 2459 negotiated by the producer or affiliate.
- 2460 (d) (i) "Noncommission compensation" includes all funds paid to or credited for the
- 2461 benefit of a licensee other than commission compensation.
- 2462 (ii) "Noncommission compensation" does not include charges for pass-through costs
- 2463 incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.
- 2464 (e) "Pass-through costs" include:
- 2465 (i) costs for copying documents to be submitted to the insurer; and
- 2466 (ii) bank costs for processing cash or credit card payments.
- 2467 (2) A licensee may receive from an insured or from a person purchasing an insurance
- 2468 policy, noncommission compensation if the noncommission compensation is stated on a
- 2469 separate, written disclosure.
- 2470 (a) The disclosure required by this Subsection (2) shall:
- 2471 (i) include the signature of the insured or prospective insured acknowledging the
- 2472 noncommission compensation;
- 2473 (ii) clearly specify:
- 2474 (A) the amount of any known noncommission compensation; and



- 2475 (B) the type and amount, if known, of any potential and contingent noncommission  
2476 compensation; and
- 2477 (iii) be provided to the insured or prospective insured before the performance of the  
2478 service.
- 2479 (b) Noncommission compensation shall be:
- 2480 (i) limited to actual or reasonable expenses incurred for services; and
- 2481 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of  
2482 business or for a specific service or services.
- 2483 (c) A copy of the signed disclosure required by this Subsection (2) shall be maintained  
2484 by any licensee who collects or receives the noncommission compensation or any portion of  
2485 the noncommission compensation.
- 2486 (d) All accounting records relating to noncommission compensation shall be  
2487 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.
- 2488 (3) (a) A licensee may receive noncommission compensation when acting as a  
2489 producer for the insured in connection with the actual sale or placement of insurance if:
- 2490 (i) the producer and the insured have agreed on the producer's noncommission  
2491 compensation; and
- 2492 (ii) the producer has disclosed to the insured the existence and source of any other  
2493 compensation that accrues to the producer as a result of the transaction.
- 2494 (b) The disclosure required by this Subsection (3) shall:
- 2495 (i) include the signature of the insured or prospective insured acknowledging the  
2496 noncommission compensation;
- 2497 (ii) clearly specify:
- 2498 (A) the amount of any known noncommission compensation;
- 2499 (B) the type and amount, if known, of any potential and contingent noncommission  
2500 compensation; and
- 2501 (C) the existence and source of any other compensation; and
- 2502 (iii) be provided to the insured or prospective insured before the performance of the  
2503 service.
- 2504 (c) The following additional noncommission compensation is authorized:
- 2505 (i) compensation received by a producer of a compensated corporate surety who under

2506 procedures approved by a rule or order of the commissioner is paid by surety bond principal  
2507 debtors for extra services;

2508 (ii) compensation received by an insurance producer who is also licensed as a public  
2509 adjuster under Section 31A-26-203, for services performed for an insured in connection with a  
2510 claim adjustment, so long as the producer does not receive or is not promised compensation for  
2511 aiding in the claim adjustment prior to the occurrence of the claim;

2512 (iii) compensation received by a consultant as a consulting fee, provided the consultant  
2513 complies with the requirements of Section 31A-23a-401; or

2514 (iv) other compensation arrangements approved by the commissioner after a finding  
2515 that they do not violate Section 31A-23a-401 and are not harmful to the public.

2516 (d) Subject to Section 31A-23a-402.5, a producer for the insured may receive  
2517 compensation from an insured through an insurer, for the negotiation and sale of a health  
2518 benefit plan, if there is a separate written agreement between the insured and the licensee for  
2519 the compensation. An insurer who passes through the compensation from the insured to the  
2520 licensee under this Subsection (3)(d) is not providing direct or indirect compensation or  
2521 commission compensation to the licensee.

2522 (4) (a) For purposes of this Subsection (4):

2523 (i) "Large customer" means an employer who, with respect to a calendar year and to a  
2524 plan year:

2525 (A) employed an average of at least 100 eligible employees on each business day  
2526 during the preceding calendar year; and

2527 (B) employs at least two employees on the first day of the plan year.

2528 (ii) "Producer" includes:

2529 (A) a producer;

2530 (B) an affiliate of a producer; or

2531 (C) a consultant.

2532 (b) A producer may not accept or receive any compensation from an insurer or third  
2533 party administrator for the initial placement of a health benefit plan, other than a hospital  
2534 confinement indemnity policy, unless prior to a large customer's initial purchase of the health  
2535 benefit plan the producer discloses in writing to the large customer that the producer will  
2536 receive compensation from the insurer or third party administrator for the placement of

2537 insurance, including the amount or type of compensation known to the producer at the time of  
2538 the disclosure.

2539 (c) A producer shall:

2540 (i) obtain the large customer's signed acknowledgment that the disclosure under  
2541 Subsection (4)(b) was made to the large customer; or

2542 (ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to  
2543 the large customer; and

2544 (B) keep the signed statement on file in the producer's office while the health benefit  
2545 plan placed with the large customer is in force.

2546 (d) A licensee who collects or receives any part of the compensation from an insurer or  
2547 third party administrator in a manner that facilitates an audit shall, while the health benefit plan  
2548 placed with the large customer is in force, maintain a copy of:

2549 (i) the signed acknowledgment described in Subsection (4)(c)(i); or

2550 (ii) the signed statement described in Subsection (4)(c)(ii).

2551 (e) Subsection (4)(c) does not apply to:

2552 (i) a person licensed as a producer who acts only as an intermediary between an insurer  
2553 and the customer's producer, including a managing general agent; or

2554 (ii) the placement of insurance in a secondary or residual market.

2555 (f) (i) A producer shall provide to a large customer listed in this Subsection (4)(f) an  
2556 annual accounting, as defined by rule made by the department in accordance with Title 63G,  
2557 Chapter 3, Utah Administrative Rulemaking Act, of all amounts the producer receives in  
2558 commission compensation from an insurer or third party administrator as a result of the sale or  
2559 placement of a health benefit plan to a large customer that is:

2560 (A) the state;

2561 (B) a political subdivision or instrumentality of the state or a combination thereof  
2562 primarily engaged in educational activities or the administration or servicing of educational  
2563 activities, including the State Board of Education and its instrumentalities, an institution of  
2564 higher education and its branches, a school district and its instrumentalities, a vocational and  
2565 technical school, and an entity arising out of a consolidation agreement between entities  
2566 described under this Subsection (4)(f)(i)(B);

2567 (C) a county, city, town, local district under Title 17B, Limited Purpose Local

2568 Government Entities - Local Districts, special service district under Title 17D, Chapter 1,  
2569 Special Service District Act, an entity created by an interlocal cooperation agreement under  
2570 Title 11, Chapter 13, Interlocal Cooperation Act, or any other governmental entity designated  
2571 in statute as a political subdivision of the state; or

2572 (D) a quasi-public corporation, that has the same meaning as defined in Section  
2573 [63E-1-102](#).

2574 (ii) The department shall pattern the annual accounting required by this Subsection  
2575 (4)(f) on the insurance related information on Internal Revenue Service Form 5500 and its  
2576 relevant attachments.

2577 (g) At the request of the department, a producer shall provide the department a copy of:

2578 (i) a disclosure required by this Subsection (4); or

2579 (ii) an Internal Revenue Service Form 5500 and its relevant attachments.

2580 (5) This section does not alter the right of any licensee to recover from an insured the  
2581 amount of any premium due for insurance effected by or through that licensee or to charge a  
2582 reasonable rate of interest upon past-due accounts.

2583 (6) This section does not apply to bail bond producers or bail enforcement agents as  
2584 defined in Section [31A-35-102](#).

2585 (7) A licensee may not receive noncommission compensation from an insurer, insured,  
2586 or enrollee for providing a service or engaging in an act that is required to be provided or  
2587 performed in order to receive commission compensation, except for the surplus lines  
2588 transactions that do not receive commissions.

2589 Section 39. Section **31A-23b-102** is amended to read:

2590 **31A-23b-102. Definitions.**

2591 As used in this chapter:

2592 [~~(1) "Compensation" is as defined in:~~]

2593 [~~(a) Subsections [31A-23a-501](#)(1)(a), (b), and (d); and~~]

2594 [~~(b) PPACA.~~]

2595 [~~(2)~~] (1) "Enroll" and "enrollment" mean to:

2596 (a) (i) obtain personally identifiable information about an individual; and

2597 (ii) inform an individual about accident and health insurance plans or public programs  
2598 offered on an exchange;

- 2599 (b) solicit insurance; or  
2600 (c) submit to the exchange:  
2601 (i) personally identifiable information about an individual; and  
2602 (ii) an individual's selection of a particular accident and health insurance plan or public  
2603 program offered on the exchange.

2604 ~~[(3)]~~ (2) (a) "Exchange" means an online marketplace that is certified by the United  
2605 States Department of Health and Human Services as either a state-based small employer  
2606 exchange or a federally facilitated individual exchange under PPACA.

2607 (b) "Exchange" does not include an online marketplace for the purchase of health  
2608 insurance if the online marketplace is not a certified exchange in accordance with Subsection  
2609 ~~[(3)]~~ (2)(a).

2610 ~~[(4)]~~ (3) "Navigator":

2611 (a) means a person who facilitates enrollment in an exchange by offering to assist, or  
2612 who advertises any services to assist, with:

2613 (i) the selection of and enrollment in a qualified health plan or a public program  
2614 offered on an exchange; or

2615 (ii) applying for premium subsidies through an exchange; and

2616 (b) includes a person who is an in-person assister or a certified application counselor as  
2617 described in federal regulations or guidance issued under PPACA.

2618 ~~[(5)]~~ (4) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

2619 ~~[(6)]~~ (5) "Public programs" means the state Medicaid program in Title 26, Chapter 18,  
2620 Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

2621 ~~[(7)]~~ (6) "Resident" is as defined by rule made by the commissioner in accordance with  
2622 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2623 ~~[(8)]~~ (7) "Solicit" is as defined in Section [31A-23a-102](#).

2624 Section 40. Section **31A-23b-202.5** is amended to read:

2625 **31A-23b-202.5. License types.**

2626 (1) A license issued under this chapter shall be issued under the license types described  
2627 in Subsection (2).

2628 (2) A license type under this chapter shall be a navigator line of authority or a certified  
2629 application counselor line of authority. A license type is intended to describe the matters to be

2630 considered under any education, examination, and training required of an applicant under this  
2631 chapter.

2632 (3) (a) A navigator line of authority includes the enrollment process as described in  
2633 Subsection [31A-23b-102](#)~~(4)~~(3)(a).

2634 (b) (i) A certified application counselor line of authority is limited to providing  
2635 information and assistance to individuals and employees about public programs and premium  
2636 subsidies available through the exchange.

2637 (ii) A certified application counselor line of authority does not allow the certified  
2638 application counselor to assist a person with the selection of or enrollment in a qualified health  
2639 plan offered on an exchange.

2640 Section 41. Section [31A-23b-209](#) is amended to read:

2641 **[31A-23b-209](#). Agency designations.**

2642 (1) An organization shall be licensed as a navigator agency if the organization acts as a  
2643 navigator.

2644 (2) A navigator agency that does business in the state shall designate an individual who  
2645 is licensed under this chapter to act on the agency's behalf.

2646 (3) A navigator agency shall report to the commissioner, at intervals and in the form  
2647 the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah  
2648 Administrative Rulemaking Act:

2649 (a) a new designation under Subsection (2); and

2650 (b) a terminated designation under Subsection (2).

2651 (4) A navigator agency shall notify an individual designee that the individual's  
2652 designation is terminated by the agency and of the reason for termination at an interval and in  
2653 the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3,  
2654 Utah Administrative Rulemaking Act.

2655 ~~(4)~~ (5) (a) A navigator agency licensed under this chapter shall report to the  
2656 commissioner the cause of termination of a designation if:

2657 (i) the reason for termination is a reason described in Subsection [31A-23b-401](#)(4)(b);

2658 or

2659 (ii) the navigator agency has knowledge that the individual licensee engaged in an  
2660 activity described in Subsection [31A-23b-401](#)(4)(b) by:

- 2661 (A) a court;
- 2662 (B) a government body; or
- 2663 (C) a self-regulatory organization, which the commissioner may define by rule made in  
2664 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
- 2665 (b) The information provided to the commissioner under Subsection [~~(4)~~] (5)(a) is a  
2666 private record under Title 63G, Chapter 2, Government Records Access and Management Act.
- 2667 (c) A navigator agency is immune from civil action, civil penalty, or damages if the  
2668 agency complies in good faith with this Subsection [~~(4)~~] (5) by reporting to the commissioner  
2669 the cause of termination of a designation.
- 2670 (d) A navigator agency is not immune from an action or resulting penalty imposed on  
2671 the reporting agency as a result of proceedings brought by or on behalf of the department if the  
2672 action is based on evidence other than the report submitted in compliance with this Subsection  
2673 [~~(4)~~] (5).
- 2674 [~~(5)~~] (6) A navigator agency licensed under this chapter may act in a capacity for which  
2675 it is licensed only through an individual who is licensed under this chapter to act in the same  
2676 capacity.
- 2677 [~~(6)~~] (7) A navigator agency licensed under this chapter shall designate and report to  
2678 the commissioner, in accordance with any rule made by the commissioner pursuant to Title  
2679 63G, Chapter 3, Utah Administrative Rulemaking Act, the name of the designated responsible  
2680 licensed individual who has authority to act on behalf of the navigator agency in the matters  
2681 pertaining to compliance with this title and orders of the commissioner.
- 2682 [~~(7)~~] (8) If a navigator agency contracts with or designates a licensee in reports  
2683 submitted under Subsection (3) or [~~(6)~~] (7), there is a rebuttable presumption that the  
2684 contracted or designated licensee acts on behalf of the navigator agency.
- 2685 [~~(8)~~] (9) (a) When a license is held by a navigator agency, both the navigator agency  
2686 itself and any individual contracted or designated under the navigator agency license are  
2687 considered the holders of the navigator agency license for purposes of this section.
- 2688 (b) If an individual contracted or designated under the navigator agency license  
2689 commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting  
2690 the navigator agency license, or assessing a forfeiture under Subsection 31A-2-308(1)(b)(i) or  
2691 (1)(c)(i), the commissioner may assess a forfeiture, suspend, revoke, or limit the license of, or

2692 take a combination of these actions against:

2693 (i) the individual;

2694 (ii) the navigator agency, if the navigator agency:

2695 (A) is reckless or negligent in its supervision of the individual; or

2696 (B) knowingly participates in the act or failure to act that is the ground for suspending,  
2697 revoking, or limiting the license, or assessing a forfeiture; or

2698 (iii) (A) the individual; and

2699 (B) the navigator agency, if the agency meets the requirements of Subsection [(8)]

2700 (9)(b)(ii).

2701 Section 42. Section **31A-23b-210** is amended to read:

2702 **31A-23b-210. Place of business and residence address -- Records.**

2703 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:

2704 (i) the address and the one or more telephone numbers of the licensee's principal place  
2705 of business; and

2706 (ii) a valid business email address at which the commissioner may contact the licensee.

2707 (b) If a licensee is an individual, in addition to complying with Subsection (1)(a), the  
2708 individual shall register and maintain with the commissioner the individual's residence address  
2709 and telephone number.

2710 (c) A licensee shall notify the commissioner within 30 days of a change of any of the  
2711 following required to be registered with the commissioner under this section:

2712 (i) an address;

2713 (ii) a telephone number; or

2714 (iii) a business email address.

2715 (2) Except as provided under Subsection (3), a licensee under this chapter shall keep at  
2716 the principal place of business address registered under Subsection (1), separate and distinct  
2717 books and records of the transactions consummated under the Utah license.

2718 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can  
2719 be obtained immediately from a central storage place or elsewhere by online computer  
2720 terminals located at the registered address.

2721 (4) (a) The books and records maintained under Subsection (2) shall be available for  
2722 the inspection by the commissioner during the business hours for a period of time after the date



2723 of the transaction as specified by the commissioner by rule, but in no case for less than the  
2724 current calendar year plus three years.

2725 (b) Discarding books and records after the applicable record retention period has  
2726 expired does not place the licensee in violation of a later-adopted longer record retention  
2727 period.

2728 Section 43. Section **31A-23b-401** is amended to read:

2729 **31A-23b-401. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
2730 **terminating a license -- Rulemaking for renewal or reinstatement.**

2731 (1) A license as a navigator under this chapter remains in force until:

2732 (a) revoked or suspended under Subsection (4);

2733 (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
2734 administrative action;

2735 (c) the licensee dies or is adjudicated incompetent as defined under:

2736 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

2737 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
2738 Minors;

2739 (d) lapsed under this section; or

2740 (e) voluntarily surrendered.

2741 (2) The following may be reinstated within one year after the day on which the license  
2742 is no longer in force:

2743 (a) a lapsed license; or

2744 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
2745 not be reinstated after the license period in which the license is voluntarily surrendered.

2746 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a  
2747 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
2748 department from pursuing additional disciplinary or other action authorized under:

2749 (a) this title; or

2750 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah

2751 Administrative Rulemaking Act.

2752 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an  
2753 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the

2754 commissioner may:

2755 (i) revoke a license;

2756 (ii) suspend a license for a specified period of 12 months or less;

2757 (iii) limit a license in whole or in part; [or]

2758 (iv) deny a license application[-];

2759 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

2760 (vi) take a combination of actions under Subsections (4)(a)(i) through (iv) and

2761 Subsection (4)(a)(v).

2762 (b) The commissioner may take an action described in Subsection (4)(a) if the  
2763 commissioner finds that the licensee:

2764 (i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or  
2765 31A-23b-206;

2766 (ii) violated:

2767 (A) an insurance statute;

2768 (B) a rule that is valid under Subsection 31A-2-201(3); or

2769 (C) an order that is valid under Subsection 31A-2-201(4);

2770 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other  
2771 delinquency proceedings in any state;

2772 (iv) failed to pay a final judgment rendered against the person in this state within 60  
2773 days after the day on which the judgment became final;

2774 (v) refused:

2775 (A) to be examined; or

2776 (B) to produce its accounts, records, and files for examination;

2777 (vi) had an officer who refused to:

2778 (A) give information with respect to the navigator's affairs; or

2779 (B) perform any other legal obligation as to an examination;

2780 (vii) provided information in the license application that is:

2781 (A) incorrect;

2782 (B) misleading;

2783 (C) incomplete; or

2784 (D) materially untrue;

2785 (viii) violated an insurance law, valid rule, or valid order of another regulatory agency  
2786 in any jurisdiction;

2787 (ix) obtained or attempted to obtain a license through misrepresentation or fraud;

2788 (x) improperly withheld, misappropriated, or converted money or properties received  
2789 in the course of doing insurance business;

2790 (xi) intentionally misrepresented the terms of an actual or proposed:

2791 (A) insurance contract;

2792 (B) application for insurance; or

2793 (C) application for public program;

2794 (xii) is convicted of a felony;

2795 (xiii) admitted or is found to have committed an insurance unfair trade practice or  
2796 fraud;

2797 (xiv) in the conduct of business in this state or elsewhere:

2798 (A) used fraudulent, coercive, or dishonest practices; or

2799 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

2800 (xv) had an insurance license, navigator license, or its equivalent, denied, suspended,  
2801 or revoked in another state, province, district, or territory;

2802 (xvi) forged another's name to:

2803 (A) an application for insurance;

2804 (B) a document related to an insurance transaction;

2805 (C) a document related to an application for a public program; or

2806 (D) a document related to an application for premium subsidies;

2807 (xvii) improperly used notes or another reference material to complete an examination  
2808 for a license;

2809 (xviii) knowingly accepted insurance business from an individual who is not licensed;

2810 (xix) failed to comply with an administrative or court order imposing a child support  
2811 obligation;

2812 (xx) failed to:

2813 (A) pay state income tax; or

2814 (B) comply with an administrative or court order directing payment of state income  
2815 tax;

2816 (xxi) violated or permitted others to violate the federal Violent Crime Control and Law  
2817 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is  
2818 prohibited from engaging in the business of insurance; or

2819 (xxii) engaged in a method or practice in the conduct of business that endangered the  
2820 legitimate interests of customers and the public.

2821 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
2822 and any individual designated under the license are considered to be the holders of the license.

2823 (d) If an individual designated under the agency license commits an act or fails to  
2824 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
2825 the commissioner may suspend, revoke, or limit the license of:

2826 (i) the individual;

2827 (ii) the agency, if the agency:

2828 (A) is reckless or negligent in its supervision of the individual; or

2829 (B) knowingly participates in the act or failure to act that is the ground for suspending,  
2830 revoking, or limiting the license; or

2831 (iii) (A) the individual; and

2832 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

2833 (5) A licensee under this chapter is subject to the penalties for acting as a licensee  
2834 without a license if:

2835 (a) the licensee's license is:

2836 (i) revoked;

2837 (ii) suspended;

2838 (iii) surrendered in lieu of administrative action;

2839 (iv) lapsed; or

2840 (v) voluntarily surrendered; and

2841 (b) the licensee:

2842 (i) continues to act as a licensee; or

2843 (ii) violates the terms of the license limitation.

2844 (6) A licensee under this chapter shall immediately report to the commissioner:

2845 (a) a revocation, suspension, or limitation of the person's license in another state, the  
2846 District of Columbia, or a territory of the United States;

2847 (b) the imposition of a disciplinary sanction imposed on that person by another state,  
2848 the District of Columbia, or a territory of the United States; or

2849 (c) a judgment or injunction entered against that person on the basis of conduct  
2850 involving:

2851 (i) fraud;

2852 (ii) deceit;

2853 (iii) misrepresentation; or

2854 (iv) a violation of an insurance law or rule.

2855 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a  
2856 license in lieu of administrative action may specify a time, not to exceed five years, within  
2857 which the former licensee may not apply for a new license.

2858 (b) If no time is specified in an order or agreement described in Subsection (7)(a), the  
2859 former licensee may not apply for a new license for five years from the day on which the order  
2860 or agreement is made without the express approval of the commissioner.

2861 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
2862 a license issued under this chapter if so ordered by a court.

2863 (9) The commissioner shall by rule prescribe the license renewal and reinstatement  
2864 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2865 Section 44. Section **31A-26-209** is amended to read:

2866 **31A-26-209. Form and contents of license.**

2867 (1) Licenses issued under this chapter shall be in the form the commissioner prescribes  
2868 and shall set forth:

2869 (a) the name, address, and the one or more telephone [~~number~~] numbers of the  
2870 licensee;

2871 (b) the license classifications under Section [31A-26-204](#);

2872 (c) the date of license issuance; and

2873 (d) any other information the commissioner considers advisable.

2874 (2) An adjuster doing business under any other name than the adjuster's legal name  
2875 shall notify the commissioner prior to using the assumed name in this state.

2876 (3) (a) An organization shall be licensed as an agency if the organization acts as:

2877 (i) an independent adjuster; or

2878 (ii) a public adjuster.

2879 (b) The agency license issued under Subsection (3)(a) shall set forth the names of all  
2880 natural persons licensed under this chapter who are authorized to act in those capacities for the  
2881 organization in this state.

2882 Section 45. Section **31A-26-210** is amended to read:

2883 **31A-26-210. Reports from organizations licensed as adjusters.**

2884 (1) An organization licensed as an adjuster under Section **31A-26-203** shall designate  
2885 an individual who has an individual adjuster license to act on the organization's behalf in order  
2886 for the licensee to do business for the organization in this state.

2887 (2) An organization licensed under this chapter shall report to the commissioner, at  
2888 intervals and in the form the commissioner establishes by rule, made in accordance with Title  
2889 63G, Chapter 3, Utah Administrative Rulemaking Act:

2890 (a) a new designation; and

2891 (b) a terminated designation.

2892 (3) An organization licensed under this chapter shall notify an individual licensee that  
2893 the individual's designation has been terminated by the organization and of the reason for the  
2894 termination at an interval and in the form the commissioner establishes by rule made in  
2895 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2896 [~~3~~] (4) (a) An organization licensed under this chapter shall report to the  
2897 commissioner the cause of termination of a designation if:

2898 (i) the reason for termination is a reason described in Subsection **31A-26-213(5)(b)**; or

2899 (ii) the organization has knowledge that the individual licensee is found to have  
2900 engaged in an activity described in Subsection **31A-26-213(5)(b)** by:

2901 (A) a court;

2902 (B) a government body; or

2903 (C) a self-regulatory organization, which the commissioner may define by rule made in  
2904 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2905 (b) The information provided the commissioner under Subsection [~~3~~] (4)(a) is a  
2906 private record under Title 63G, Chapter 2, Government Records Access and Management Act.

2907 (c) An organization is immune from civil action, civil penalty, or damages if the  
2908 organization complies in good faith with this Subsection [~~3~~] (4) in reporting to the

2909 commissioner the cause of termination of a designation.

2910 (d) Notwithstanding any other provision in this section, an organization is not immune  
2911 from an action or resulting penalty imposed on the reporting organization as a result of a  
2912 proceeding brought by or on behalf of the department if the action is based on evidence other  
2913 than the report submitted in compliance with this Subsection [~~(3)~~] (4).

2914 [~~(4)~~] (5) An organization licensed under this chapter may act in a capacity for which it  
2915 is licensed only through an individual who is licensed under this chapter to act in the same  
2916 capacity.

2917 [~~(5)~~] (6) An organization licensed under this chapter shall designate and report  
2918 promptly to the commissioner the name of the designated responsible licensed individual who  
2919 has authority to act on behalf of the organization in all matters pertaining to compliance with  
2920 this title and orders of the commissioner.

2921 [~~(6)~~] (7) If an agency contracts with or designates a licensee in a report submitted under  
2922 Subsection (2) or [~~(5)~~] (6), there is a rebuttable presumption that the contracted or designated  
2923 licensee acts on behalf of the agency.

2924 [~~(7)~~] (8) (a) When a license is held by an organization, both the organization itself and  
2925 an individual contracted or designated under the license shall, for purposes of this section, be  
2926 considered to be the holders of the organization license.

2927 (b) If an individual designated under the organization license commits an act or fails to  
2928 perform a duty that is a ground for suspending, revoking, or limiting the organization license,  
2929 the commissioner may assess a forfeiture against, suspend, revoke, or limit the license of, or  
2930 take a combination of these actions against:

2931 (i) that individual;

2932 (ii) the organization, if the organization:

2933 (A) is reckless or negligent in its supervision of the individual; or

2934 (B) knowingly participates in the act or failure to act that is the ground for assessing a  
2935 forfeiture or suspending, revoking, or limiting the license; or

2936 (iii) (A) the individual; and

2937 (B) the organization, if the organization meets the requirements of Subsection [~~(7)~~]

2938 (8)(b)(ii).

2939 Section 46. Section **31A-26-213** is amended to read:

2940           **31A-26-213. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
2941 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**

- 2942           (1) A license type issued under this chapter remains in force until:
- 2943           (a) revoked or suspended under Subsection (5);
  - 2944           (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
2945 administrative action;
  - 2946           (c) the licensee dies or is adjudicated incompetent as defined under:
    - 2947           (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
    - 2948           (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
2949 Minors;
  - 2950           (d) lapsed under Section [31A-26-214.5](#); or
  - 2951           (e) voluntarily surrendered.

2952           (2) The following may be reinstated within one year after the day on which the license  
2953 is no longer in force:

- 2954           (a) a lapsed license; or
- 2955           (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
2956 not be reinstated after the license period in which it is voluntarily surrendered.

2957           (3) Unless otherwise stated in a written agreement for the voluntary surrender of a  
2958 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
2959 department from pursuing additional disciplinary or other action authorized under:

- 2960           (a) this title; or
- 2961           (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah  
2962 Administrative Rulemaking Act.

2963           (4) A license classification issued under this chapter remains in force until:

- 2964           (a) the qualifications pertaining to a license classification are no longer met by the  
2965 licensee; or
- 2966           (b) the supporting license type:
  - 2967           (i) is revoked or suspended under Subsection (5); or
  - 2968           (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of  
2969 administrative action.

2970           (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an



2971 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
2972 commissioner may:

2973 (i) revoke:

2974 (A) a license; or

2975 (B) a license classification;

2976 (ii) suspend for a specified period of 12 months or less:

2977 (A) a license; or

2978 (B) a license classification;

2979 (iii) limit in whole or in part:

2980 (A) a license; or

2981 (B) a license classification; [~~or~~]

2982 (iv) deny a license application[-];

2983 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

2984 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and

2985 Subsection (5)(a)(v).

2986 (b) The commissioner may take an action described in Subsection (5)(a) if the  
2987 commissioner finds that the licensee:

2988 (i) is unqualified for a license or license classification under Section 31A-26-202,  
2989 31A-26-203, 31A-26-204, or 31A-26-205;

2990 (ii) has violated:

2991 (A) an insurance statute;

2992 (B) a rule that is valid under Subsection 31A-2-201(3); or

2993 (C) an order that is valid under Subsection 31A-2-201(4);

2994 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other  
2995 delinquency proceedings in any state;

2996 (iv) fails to pay a final judgment rendered against the person in this state within 60  
2997 days after the judgment became final;

2998 (v) fails to meet the same good faith obligations in claims settlement that is required of  
2999 admitted insurers;

3000 (vi) is affiliated with and under the same general management or interlocking  
3001 directorate or ownership as another insurance adjuster that transacts business in this state

- 3002 without a license;
- 3003 (vii) refuses:
- 3004 (A) to be examined; or
- 3005 (B) to produce its accounts, records, and files for examination;
- 3006 (viii) has an officer who refuses to:
- 3007 (A) give information with respect to the insurance adjuster's affairs; or
- 3008 (B) perform any other legal obligation as to an examination;
- 3009 (ix) provides information in the license application that is:
- 3010 (A) incorrect;
- 3011 (B) misleading;
- 3012 (C) incomplete; or
- 3013 (D) materially untrue;
- 3014 (x) has violated an insurance law, valid rule, or valid order of another regulatory
- 3015 agency in any jurisdiction;
- 3016 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 3017 (xii) has improperly withheld, misappropriated, or converted money or properties
- 3018 received in the course of doing insurance business;
- 3019 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 3020 (A) insurance contract; or
- 3021 (B) application for insurance;
- 3022 (xiv) has been convicted of a felony;
- 3023 (xv) has admitted or been found to have committed an insurance unfair trade practice
- 3024 or fraud;
- 3025 (xvi) in the conduct of business in this state or elsewhere has:
- 3026 (A) used fraudulent, coercive, or dishonest practices; or
- 3027 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 3028 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in
- 3029 any other state, province, district, or territory;
- 3030 (xviii) has forged another's name to:
- 3031 (A) an application for insurance; or
- 3032 (B) a document related to an insurance transaction;

- 3033 (xix) has improperly used notes or any other reference material to complete an  
3034 examination for an insurance license;
- 3035 (xx) has knowingly accepted insurance business from an individual who is not  
3036 licensed;
- 3037 (xxi) has failed to comply with an administrative or court order imposing a child  
3038 support obligation;
- 3039 (xxii) has failed to:
- 3040 (A) pay state income tax; or  
3041 (B) comply with an administrative or court order directing payment of state income  
3042 tax;
- 3043 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and  
3044 Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is  
3045 prohibited from engaging in the business of insurance; or
- 3046 (xxiv) has engaged in methods and practices in the conduct of business that endanger  
3047 the legitimate interests of customers and the public.
- 3048 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
3049 and any individual designated under the license are considered to be the holders of the license.
- 3050 (d) If an individual designated under the agency license commits an act or fails to  
3051 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
3052 the commissioner may suspend, revoke, or limit the license of:
- 3053 (i) the individual;
- 3054 (ii) the agency, if the agency:
- 3055 (A) is reckless or negligent in its supervision of the individual; or  
3056 (B) knowingly participated in the act or failure to act that is the ground for suspending,  
3057 revoking, or limiting the license; or
- 3058 (iii) (A) the individual; and  
3059 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
- 3060 (6) A licensee under this chapter is subject to the penalties for conducting an insurance  
3061 business without a license if:
- 3062 (a) the licensee's license is:
- 3063 (i) revoked;

- 3064 (ii) suspended;
- 3065 (iii) limited;
- 3066 (iv) surrendered in lieu of administrative action;
- 3067 (v) lapsed; or
- 3068 (vi) voluntarily surrendered; and
- 3069 (b) the licensee:
  - 3070 (i) continues to act as a licensee; or
  - 3071 (ii) violates the terms of the license limitation.
- 3072 (7) A licensee under this chapter shall immediately report to the commissioner:
  - 3073 (a) a revocation, suspension, or limitation of the person's license in any other state, the
  - 3074 District of Columbia, or a territory of the United States;
  - 3075 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
  - 3076 the District of Columbia, or a territory of the United States; or
  - 3077 (c) a judgment or injunction entered against that person on the basis of conduct
  - 3078 involving:
    - 3079 (i) fraud;
    - 3080 (ii) deceit;
    - 3081 (iii) misrepresentation; or
    - 3082 (iv) a violation of an insurance law or rule.
- 3083 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
- 3084 license in lieu of administrative action may specify a time not to exceed five years within
- 3085 which the former licensee may not apply for a new license.
  - 3086 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the
  - 3087 former licensee may not apply for a new license for five years without the express approval of
  - 3088 the commissioner.
- 3089 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
- 3090 a license issued under this part if so ordered by a court.
- 3091 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
- 3092 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
- 3093 Section 47. Section **31A-26-312** is enacted to read:
- 3094 **31A-26-312. Prohibited conduct.**

- 3095 (1) An independent adjuster or public adjuster may not:  
3096 (a) participate directly or indirectly in the reconstruction, repair, or restoration of  
3097 damaged property that is the subject of a claim adjusted by the independent adjuster or public  
3098 adjuster;  
3099 (b) engage in any other activities that may reasonably be construed as presenting a  
3100 conflict of interest, including soliciting or accepting remuneration from, or having a financial  
3101 interest in, or deriving any direct or indirect financial benefit from, a salvage firm, repair firm,  
3102 construction firm, or other firm that obtains business in connection with a claim that the  
3103 independent adjuster or public adjuster has a contract or agreement to adjust;  
3104 (c) subject to Subsection (2), directly or indirectly solicit employment for an attorney  
3105 or enter into a contract with an insured for the primary purpose of referring an insured to an  
3106 attorney and without actually performing the services customarily provided by an independent  
3107 adjuster or public adjuster;  
3108 (d) act on behalf of an attorney in having an insured sign an attorney representation  
3109 agreement; or  
3110 (e) accept a fee, commission, or other valuable consideration of any nature, regardless  
3111 of form or amount, in exchange for the referral by an independent adjuster or public adjuster of  
3112 an insured to a third-party person, including an attorney, appraiser, umpire, construction  
3113 company, contractor, repair firm, or salvage company.  
3114 (2) Subsection (1)(c) may not be construed to prohibit an independent adjuster or  
3115 public adjuster from recommending a specific attorney to an insured.  
3116 (3) An independent adjuster or public adjuster who violates this section is subject to  
3117 Section [31A-2-308](#).

3118 Section 48. Section **31A-26-401** is enacted to read:

3119 **Part 4. Public Adjusters**

3120 **31A-26-401. Required contracts.**

- 3121 (1) A public adjuster may not, directly or indirectly, act within this state as a public  
3122 adjuster without having first entered into a contract, in writing, on a form filed with the  
3123 department in accordance with Section [31A-21-201](#), executed in duplicate by the public  
3124 adjuster and the insured or the insured's duly authorized representative. A public adjuster may  
3125 not use a form of contract that is not filed with the department.

3126 (2) A contract described in Subsection (1) is subject to rescission in accordance with  
3127 Section 31A-26-311.

3128 (3) (a) A contract described in Subsection (1) shall include a prominently displayed  
3129 notice in 12-point boldface type that states "WE REPRESENT THE INSURED ONLY."

3130 (b) The commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah  
3131 Administrative Rulemaking Act, may require additional prominently displayed notice  
3132 requirements in the contract as the commissioner considers necessary.

3133 (4) A public adjuster shall keep at the public adjuster's principal place of business in  
3134 this state a copy of each contract entered into in this state for this current year plus three years,  
3135 and each contract shall be available at all times for inspection, without notice, by the  
3136 commissioner or the commissioner's authorized representative.

3137 (5) A public adjuster may not enter into a contract with an insured and collect  
3138 compensation as provided in the contract without actually performing the services customarily  
3139 provided by a licensed public adjuster for the insured.

3140 Section 49. Section **31A-26-402** is enacted to read:

3141 **31A-26-402. Compensation.**

3142 (1) Except as provided by Subsection (2), a public adjuster may receive compensation  
3143 for service provided under this chapter consisting of an hourly fee, a flat rate, a percentage of  
3144 the total amount paid by an insurer to resolve a claim, or another method of compensation. The  
3145 total compensation received may not exceed 10% of the amount of the insurance settlement on  
3146 the claim.

3147 (2) (a) A public adjuster may not receive a compensation consisting of a percentage of  
3148 the total amount paid by an insurer to resolve a claim on a claim on which the insurer, not later  
3149 than 72 hours after the date on which the loss is reported to the insurer, either pays or commits  
3150 in writing to pay to the insured the policy limit of the insurance policy.

3151 (b) A public adjuster is entitled to reasonable compensation from the insured for  
3152 services provided by the public adjuster on behalf of the insured, based on the time spent on a  
3153 claim that is subject to this Subsection (2) and expenses incurred by the public adjuster, until  
3154 the claim is paid or the insured receives a written commitment to pay from the insurer.

3155 (3) Except for the payment of compensation by the insured, a person paying proceeds  
3156 of a policy of insurance or making a payment affecting an insured's rights under a policy of

3157 insurance shall:

3158 (a) include the insured as a payee on the payment draft or check; and

3159 (b) require the written signature and endorsement of the insured on the payment draft  
3160 or check.

3161 (4) A public adjuster may not accept any payment that violates this section  
3162 notwithstanding whether the insured gives authorization to the public adjuster. A public  
3163 adjuster may not sign and endorse any payment draft or check on behalf of an insured.

3164 Section 50. Section **31A-26-403** is enacted to read:

3165 **31A-26-403. Rulemaking.**

3166 The commissioner may make rules, in accordance with Title 63G, Chapter 3, Utah  
3167 Administrative Rulemaking Act:

3168 (1) addressing the forms required by this part;

3169 (2) providing for notice requirements in contracts; and

3170 (3) establishing the scope of a contract a public adjuster enters into with an insured that  
3171 the public adjuster represents.

3172 Section 51. Section **31A-30-106** is amended to read:

3173 **31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.**

3174 (1) Premium rates for health benefit plans for individuals under this chapter are subject  
3175 to this section.

3176 (a) The index rate for a rating period for any class of business may not exceed the  
3177 index rate for any other class of business by more than 20%.

3178 (b) (i) For a class of business, the premium rates charged during a rating period to  
3179 covered insureds with similar case characteristics for the same or similar coverage, or the rates  
3180 that could be charged to the individual under the rating system for that class of business, may  
3181 not vary from the index rate by more than 30% of the index rate except as provided under  
3182 Subsection (1)(b)(ii).

3183 (ii) A carrier that offers individual and small employer health benefit plans may use the  
3184 small employer index rates to establish the rate limitations for individual policies, even if some  
3185 individual policies are rated below the small employer base rate.

3186 (c) The percentage increase in the premium rate charged to a covered insured for a new  
3187 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of

3188 the following:

3189 (i) the percentage change in the new business premium rate measured from the first day  
3190 of the prior rating period to the first day of the new rating period;

3191 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods  
3192 of less than one year, due to the claim experience, health status, or duration of coverage of the  
3193 covered individuals as determined from the rate manual for the class of business of the carrier  
3194 offering an individual health benefit plan; and

3195 (iii) any adjustment due to change in coverage or change in the case characteristics of  
3196 the covered insured as determined from the rate manual for the class of business of the carrier  
3197 offering an individual health benefit plan.

3198 (d) (i) A carrier offering an individual health benefit plan shall apply rating factors,  
3199 including case characteristics, consistently with respect to all covered insureds in a class of  
3200 business.

3201 (ii) Rating factors shall produce premiums for identical individuals that:

3202 (A) differ only by the amounts attributable to plan design; and

3203 (B) do not reflect differences due to the nature of the individuals assumed to select  
3204 particular health benefit ~~[products]~~ plans.

3205 (iii) A carrier offering an individual health benefit plan shall treat all health benefit  
3206 plans issued or renewed in the same calendar month as having the same rating period.

3207 (e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted  
3208 network provision may not be considered similar coverage to a health benefit plan that does not  
3209 use a restricted network provision, provided that use of the restricted network provision results  
3210 in substantial difference in claims costs.

3211 (f) A carrier offering a health benefit plan to an individual may not, without prior  
3212 approval of the commissioner, use case characteristics other than:

3213 (i) age;

3214 (ii) gender;

3215 (iii) geographic area; and

3216 (iv) family composition.

3217 (g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3,  
3218 Utah Administrative Rulemaking Act, to:



- 3219 (A) implement this chapter;
- 3220 (B) assure that rating practices used by carriers who offer health benefit plans to  
3221 individuals are consistent with the purposes of this chapter; and
- 3222 (C) promote transparency of rating practices of health benefit plans, except that a  
3223 carrier may not be required to disclose proprietary information.
- 3224 (ii) The rules described in Subsection (1)(g)(i) may include rules that:
- 3225 (A) assure that differences in rates charged for health benefit [products] plans by  
3226 carriers who offer health benefit plans to individuals are reasonable and reflect objective  
3227 differences in plan design, not including differences due to the nature of the individuals  
3228 assumed to select particular health benefit [products] plans; and
- 3229 (B) prescribe the manner in which case characteristics may be used by carriers who  
3230 offer health benefit plans to individuals.
- 3231 (h) The commissioner shall revise rules issued for Sections [31A-22-602](#) and  
3232 [31A-22-605](#) regarding individual accident and health policy rates to allow rating in accordance  
3233 with this section.
- 3234 (2) For purposes of Subsection (1)(c)(i), if a health benefit [product] plan is a health  
3235 benefit [product] plan into which the covered carrier is no longer enrolling new covered  
3236 insureds, the covered carrier shall use the percentage change in the base premium rate,  
3237 provided that the change does not exceed, on a percentage basis, the change in the new  
3238 business premium rate for the most similar health benefit product into which the covered  
3239 carrier is actively enrolling new covered insureds.
- 3240 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of  
3241 a class of business.
- 3242 (b) A covered carrier may not offer to transfer a covered insured into or out of a class  
3243 of business unless the offer is made to transfer all covered insureds in the class of business  
3244 without regard to:
- 3245 (i) case characteristics;
- 3246 (ii) claim experience;
- 3247 (iii) health status; or
- 3248 (iv) duration of coverage since issue.
- 3249 (4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the

3250 carrier's principal place of business a complete and detailed description of its rating practices  
3251 and renewal underwriting practices, including information and documentation that demonstrate  
3252 that the carrier's rating methods and practices are:

3253 (i) based upon commonly accepted actuarial assumptions; and

3254 (ii) in accordance with sound actuarial principles.

3255 (b) (i) A carrier subject to this section shall file with the commissioner, on or before  
3256 April 1 of each year, in a form, manner, and containing such information as prescribed by the  
3257 commissioner, an actuarial certification certifying that:

3258 (A) the carrier is in compliance with this chapter; and

3259 (B) the rating methods of the carrier are actuarially sound.

3260 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the  
3261 carrier at the carrier's principal place of business.

3262 (c) A carrier shall make the information and documentation described in this  
3263 Subsection (4) available to the commissioner upon request.

3264 (d) Except as provided in Subsection (1)(g) or required by PPACA, a record submitted  
3265 to the commissioner under this section shall be maintained by the commissioner as a protected  
3266 record under Title 63G, Chapter 2, Government Records Access and Management Act.

3267 Section 52. Section **31A-30-106.1** is amended to read:

3268 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**

3269 (1) Premium rates for small employer health benefit plans under this chapter are  
3270 subject to this section.

3271 (2) (a) The index rate for a rating period for any class of business may not exceed the  
3272 index rate for any other class of business by more than 20%.

3273 (b) For a class of business, the premium rates charged during a rating period to covered  
3274 insureds with similar case characteristics for the same or similar coverage, or the rates that  
3275 could be charged to an employer group under the rating system for that class of business, may  
3276 not vary from the index rate by more than 30% of the index rate, except when catastrophic  
3277 mental health coverage is selected as provided in Subsection [31A-22-625\(2\)\(d\)](#).

3278 (3) The percentage increase in the premium rate charged to a covered insured for a new  
3279 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of  
3280 the following:

3281 (a) the percentage change in the new business premium rate measured from the first  
3282 day of the prior rating period to the first day of the new rating period;

3283 (b) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods  
3284 of less than one year, due to the claim experience, health status, or duration of coverage of the  
3285 covered individuals as determined from the small employer carrier's rate manual for the class of  
3286 business, except when catastrophic mental health coverage is selected as provided in  
3287 Subsection 31A-22-625(2)(d); and

3288 (c) any adjustment due to change in coverage or change in the case characteristics of  
3289 the covered insured as determined for the class of business from the small employer carrier's  
3290 rate manual.

3291 (4) (a) Adjustments in rates for claims experience, health status, and duration from  
3292 issue may not be charged to individual employees or dependents.

3293 (b) Rating adjustments and factors, including case characteristics, shall be applied  
3294 uniformly and consistently to the rates charged for all employees and dependents of the small  
3295 employer.

3296 (c) Rating factors shall produce premiums for identical groups that:

3297 (i) differ only by the amounts attributable to plan design; and

3298 (ii) do not reflect differences due to the nature of the groups assumed to select  
3299 particular health benefit [~~products~~] plans.

3300 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the  
3301 same calendar month as having the same rating period.

3302 (5) A health benefit plan that uses a restricted network provision may not be considered  
3303 similar coverage to a health benefit plan that does not use a restricted network provision,  
3304 provided that use of the restricted network provision results in substantial difference in claims  
3305 costs.

3306 (6) The small employer carrier may not use case characteristics other than the  
3307 following:

3308 (a) age of the employee, in accordance with Subsection (7);

3309 (b) geographic area;

3310 (c) family composition in accordance with Subsection (9);

3311 (d) for plans renewed or effective on or after July 1, 2011, gender of the employee and

- 3312 spouse;
- 3313 (e) for an individual age 65 and older, whether the employer policy is primary or
- 3314 secondary to Medicare; and
- 3315 (f) a wellness program, in accordance with Subsection (12).
- 3316 (7) Age limited to:
- 3317 (a) the following age bands:
- 3318 (i) less than 20;
- 3319 (ii) 20-24;
- 3320 (iii) 25-29;
- 3321 (iv) 30-34;
- 3322 (v) 35-39;
- 3323 (vi) 40-44;
- 3324 (vii) 45-49;
- 3325 (viii) 50-54;
- 3326 (ix) 55-59;
- 3327 (x) 60-64; and
- 3328 (xi) 65 and above; and
- 3329 (b) a standard slope ratio range for each age band, applied to each family composition
- 3330 tier rating structure under Subsection (9)(b):
- 3331 (i) as developed by the commissioner by administrative rule; and
- 3332 (ii) not to exceed an overall ratio as provided in Subsection (8).
- 3333 (8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:
- 3334 (i) 5:1 for plans renewed or effective before January 1, 2012; and
- 3335 (ii) 6:1 for plans renewed or effective on or after January 1, 2012; and
- 3336 (b) the age slope ratios for each age band may not overlap.
- 3337 (9) Except as provided in Subsection [31A-30-207\(2\)](#), family composition is limited to:
- 3338 (a) an overall ratio of:
- 3339 (i) 5:1 or less for plans renewed or effective before January 1, 2012; and
- 3340 (ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and
- 3341 (b) a tier rating structure that includes:
- 3342 (i) four tiers that include:

- 3343 (A) employee only;
- 3344 (B) employee plus spouse;
- 3345 (C) employee plus a child or children; and
- 3346 (D) a family, consisting of an employee plus spouse, and a child or children;
- 3347 (ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:
- 3348 (A) employee only;
- 3349 (B) employee plus spouse;
- 3350 (C) employee plus one child;
- 3351 (D) employee plus two or more children; and
- 3352 (E) employee plus spouse plus one or more children; or
- 3353 (iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:
- 3354 (A) employee only;
- 3355 (B) employee plus spouse;
- 3356 (C) employee plus one child;
- 3357 (D) employee plus two or more children;
- 3358 (E) employee plus spouse plus one child; and
- 3359 (F) employee plus spouse plus two or more children.
- 3360 (10) If a health benefit plan is a health benefit plan into which the small employer
- 3361 carrier is no longer enrolling new covered insureds, the small employer carrier shall use the
- 3362 percentage change in the base premium rate, provided that the change does not exceed, on a
- 3363 percentage basis, the change in the new business premium rate for the most similar health
- 3364 benefit [~~product~~] plan into which the small employer carrier is actively enrolling new covered
- 3365 insureds.
- 3366 (11) (a) A covered carrier may not transfer a covered insured involuntarily into or out
- 3367 of a class of business.
- 3368 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
- 3369 of business unless the offer is made to transfer all covered insureds in the class of business
- 3370 without regard to:
- 3371 (i) case characteristics;
- 3372 (ii) claim experience;
- 3373 (iii) health status; or

- 3374 (iv) duration of coverage since issue.
- 3375 (12) Notwithstanding Subsection (4)(b), a small employer carrier may:
- 3376 (a) offer a wellness program to a small employer group if:
- 3377 (i) the premium discount to the employer for the wellness program does not exceed
- 3378 20% of the premium for the small employer group; and
- 3379 (ii) the carrier offers the wellness program discount uniformly across all small
- 3380 employer groups;
- 3381 (b) offer a premium discount as part of a wellness program to individual employees in
- 3382 a small employer group:
- 3383 (i) to the extent allowed by federal law; and
- 3384 (ii) if the employee discount based on the wellness program is offered uniformly across
- 3385 all small employer groups; and
- 3386 (c) offer a combination of premium discounts for the employer and the employee,
- 3387 based on a wellness program, if:
- 3388 (i) the employer discount complies with Subsection (12)(a); and
- 3389 (ii) the employee discount complies with Subsection (12)(b).
- 3390 (13) (a) [~~Each~~] A small employer carrier shall maintain at the small employer carrier's
- 3391 principal place of business a complete and detailed description of its rating practices and
- 3392 renewal underwriting practices, including information and documentation that demonstrate that
- 3393 the small employer carrier's rating methods and practices are:
- 3394 (i) based upon commonly accepted actuarial assumptions; and
- 3395 (ii) in accordance with sound actuarial principles.
- 3396 (b) (i) [~~Each~~] A small employer carrier shall file with the commissioner on or before
- 3397 April 1 of each year, in a form and manner and containing information as prescribed by the
- 3398 commissioner, an actuarial certification certifying that:
- 3399 (A) the small employer carrier is in compliance with this chapter; and
- 3400 (B) the rating methods of the small employer carrier are actuarially sound.
- 3401 (ii) A copy of the certification required by Subsection (13)(b)(i) shall be retained by the
- 3402 small employer carrier at the small employer carrier's principal place of business.
- 3403 (c) A small employer carrier shall make the information and documentation described
- 3404 in this Subsection (13) available to the commissioner upon request.

3405 (14) (a) The commissioner shall establish rules in accordance with Title 63G, Chapter  
3406 3, Utah Administrative Rulemaking Act, to:

3407 (i) implement this chapter; and

3408 (ii) assure that rating practices used by small employer carriers under this section and  
3409 carriers for individual plans under Section 31A-30-106 are consistent with the purposes of this  
3410 chapter.

3411 (b) The rules may:

3412 (i) assure that differences in rates charged for health benefit plans by carriers are  
3413 reasonable and reflect objective differences in plan design, not including differences due to the  
3414 nature of the groups or individuals assumed to select particular health benefit plans; and

3415 (ii) prescribe the manner in which case characteristics may be used by small employer  
3416 and individual carriers.

3417 (15) Records submitted to the commissioner under this section shall be maintained by  
3418 the commissioner as protected records under Title 63G, Chapter 2, Government Records  
3419 Access and Management Act.

3420 Section 53. Section 31A-30-107 is amended to read:

3421 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**  
3422 **nonrenewal.**

3423 (1) Except as otherwise provided in this section, a small employer health benefit plan is  
3424 renewable and continues in force:

3425 (a) with respect to all eligible employees and dependents; and

3426 (b) at the option of the plan sponsor.

3427 (2) A small employer health benefit plan may be discontinued or nonrenewed:

3428 (a) for a network plan, if there is no longer any enrollee under the group health plan  
3429 who lives, resides, or works in:

3430 (i) the service area of the covered carrier; or

3431 (ii) the area for which the covered carrier is authorized to do business; or

3432 (b) for coverage made available in the small or large employer market only through an  
3433 association, if:

3434 (i) the employer's membership in the association ceases; and

3435 (ii) the coverage is terminated uniformly without regard to any health status-related

3436 factor relating to any covered individual.

3437 (3) A small employer health benefit plan may be discontinued if:

3438 (a) a condition described in Subsection (2) exists;

3439 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay

3440 premiums or contributions in accordance with the terms of the contract;

3441 (c) the plan sponsor:

3442 (i) performs an act or practice that constitutes fraud; or

3443 (ii) makes an intentional misrepresentation of material fact under the terms of the

3444 coverage;

3445 (d) the covered carrier:

3446 (i) elects to discontinue offering a particular small employer health benefit [~~product~~]

3447 plan delivered or issued for delivery in this state; and

3448 (ii) (A) provides notice of the discontinuation in writing:

3449 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

3450 (II) at least 90 days before the date the coverage will be discontinued;

3451 (B) provides notice of the discontinuation in writing:

3452 (I) to the commissioner; and

3453 (II) at least three working days prior to the date the notice is sent to the affected plan

3454 sponsors, employees, and dependents of the plan sponsors or employees;

3455 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all

3456 other small employer health benefit [~~products~~] plans currently being offered by the small

3457 employer carrier in the market; and

3458 (D) in exercising the option to discontinue that [~~product~~] health benefit plan and in

3459 offering the option of coverage in this section, acts uniformly without regard to:

3460 (I) the claims experience of a plan sponsor;

3461 (II) any health status-related factor relating to any covered participant or beneficiary; or

3462 (III) any health status-related factor relating to any new participant or beneficiary who

3463 may become eligible for the coverage; or

3464 (e) the covered carrier:

3465 (i) elects to discontinue all of the covered carrier's small employer health benefit plans

3466 in:



- 3467 (A) the small employer market;
- 3468 (B) the large employer market; or
- 3469 (C) both the small employer and large employer markets; and
- 3470 (ii) (A) provides notice of the discontinuation in writing:
- 3471 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
- 3472 (II) at least 180 days before the date the coverage will be discontinued;
- 3473 (B) provides notice of the discontinuation in writing:
- 3474 (I) to the commissioner in each state in which an affected insured individual is known
- 3475 to reside; and
- 3476 (II) at least 30 working days prior to the date the notice is sent to the affected plan
- 3477 sponsors, employees, and the dependents of the plan sponsors or employees;
- 3478 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
- 3479 market; and
- 3480 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
- 3481 (4) A small employer health benefit plan may be discontinued or nonrenewed:
- 3482 (a) if a condition described in Subsection (2) exists; or
- 3483 (b) except as prohibited by Section [31A-30-206](#), for noncompliance with the insurer's
- 3484 employer contribution requirements.
- 3485 (5) A small employer health benefit plan may be nonrenewed:
- 3486 (a) if a condition described in Subsection (2) exists; or
- 3487 (b) except as prohibited by Section [31A-30-206](#), for noncompliance with the insurer's
- 3488 minimum participation requirements.
- 3489 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
- 3490 discontinued if after issuance of coverage the eligible employee:
- 3491 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
- 3492 or
- 3493 (ii) makes an intentional misrepresentation of material fact in connection with the
- 3494 coverage.
- 3495 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
- 3496 (i) 12 months after the date of discontinuance; and
- 3497 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies

3498 to reenroll.

3499 (c) At the time the eligible employee's coverage is discontinued under Subsection  
3500 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when  
3501 coverage is discontinued.

3502 (d) An eligible employee may not be discontinued under this Subsection (6) because of  
3503 a fraud or misrepresentation that relates to health status.

3504 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to  
3505 the employer:

3506 (a) with respect to coverage provided to an employer member of the association; and

3507 (b) if the small employer health benefit plan is made available by a covered carrier in  
3508 the employer market only through:

3509 (i) an association;

3510 (ii) a trust; or

3511 (iii) a discretionary group.

3512 (8) A covered carrier may modify a small employer health benefit plan only:

3513 (a) at the time of coverage renewal; and

3514 (b) if the modification is effective uniformly among all plans with that product.

3515 Section 54. Section **31A-30-107.1** is amended to read:

3516 **31A-30-107.1. Individual discontinuance and nonrenewal.**

3517 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an  
3518 individual basis is renewable and continues in force:

3519 (i) with respect to all individuals or dependents; and

3520 (ii) at the option of the individual.

3521 (b) Subsection (1)(a) applies regardless of:

3522 (i) whether the contract is issued through:

3523 (A) a trust;

3524 (B) an association;

3525 (C) a discretionary group; or

3526 (D) other similar grouping; or

3527 (ii) the situs of delivery of the policy or contract.

3528 (2) A health benefit plan may be discontinued or nonrenewed:

- 3529 (a) for a network plan, if:
- 3530 (i) the individual no longer lives, resides, or works in:
- 3531 (A) the service area of the covered carrier; or
- 3532 (B) the area for which the covered carrier is authorized to do business; and
- 3533 (ii) coverage is terminated uniformly without regard to any health status-related factor
- 3534 relating to any covered individual; or
- 3535 (b) for coverage made available through an association, if:
- 3536 (i) the individual's membership in the association ceases; and
- 3537 (ii) the coverage is terminated uniformly without regard to any health status-related
- 3538 factor of covered individuals.
- 3539 (3) A health benefit plan may be discontinued if:
- 3540 (a) a condition described in Subsection (2) exists;
- 3541 (b) the individual fails to pay premiums or contributions in accordance with the terms
- 3542 of the health benefit plan, including any timeliness requirements;
- 3543 (c) the individual:
- 3544 (i) performs an act or practice that constitutes fraud in connection with the coverage; or
- 3545 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 3546 coverage;
- 3547 (d) the covered carrier:
- 3548 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or
- 3549 issued for delivery in this state; and
- 3550 (ii) (A) provides notice of the discontinuance in writing:
- 3551 (I) to each individual provided coverage; and
- 3552 (II) at least 90 days before the date the coverage will be discontinued;
- 3553 (B) provides notice of the discontinuation in writing:
- 3554 (I) to the commissioner; and
- 3555 (II) at least three working days prior to the date the notice is sent to the affected
- 3556 individuals;
- 3557 (C) offers to each covered individual on a guaranteed issue basis the option to purchase
- 3558 all other individual health benefit [~~products~~] plans currently being offered by the covered
- 3559 carrier for individuals in that market; and

- 3560 (D) acts uniformly without regard to any health status-related factor of a covered
- 3561 individual or dependent of a covered individual who may become eligible for coverage; or
- 3562 (e) the covered carrier:
- 3563 (i) elects to discontinue all of the covered carrier's health benefit plans in the individual
- 3564 market; and
- 3565 (ii) (A) provides notice of the discontinuation in writing:
- 3566 (I) to each covered individual; and
- 3567 (II) at least 180 days before the date the coverage will be discontinued;
- 3568 (B) provides notice of the discontinuation in writing:
- 3569 (I) to the commissioner in each state in which an affected insured individual is known
- 3570 to reside; and
- 3571 (II) at least 30 working days prior to the date the notice is sent to the affected
- 3572 individuals;
- 3573 (C) discontinues and nonrenews all health benefit plans the covered carrier issues or
- 3574 delivers for issuance in the individual market; and
- 3575 (D) acts uniformly without regard to any health status-related factor of a covered
- 3576 individual or a dependent of a covered individual who may become eligible for coverage.

3577 Section 55. Section **31A-37-102** is amended to read:

3578 **31A-37-102. Definitions.**

3579 As used in this chapter:

3580 (1) (a) "Affiliated company" means a business entity that because of common

3581 ownership, control, operation, or management is in the same corporate or limited liability

3582 company system as:

- 3583 [~~(a)~~] (i) a parent;
- 3584 [~~(b)~~] (ii) an industrial insured; or
- 3585 [~~(c)~~] (iii) a member organization.

3586 (b) Notwithstanding Subsection (1)(a), the commissioner may issue an order finding

3587 that a business entity is not an affiliated company.

- 3588 (2) "Alien captive insurance company" means an insurer:
- 3589 (a) formed to write insurance business for a parent or affiliate of the insurer; and
- 3590 (b) licensed pursuant to the laws of an alien or foreign jurisdiction that imposes

3591 statutory or regulatory standards:

3592 (i) on a business entity transacting the business of insurance in the alien or foreign  
3593 jurisdiction; and

3594 (ii) in a form acceptable to the commissioner.

3595 (3) "Association" means a legal association of two or more persons that has been in  
3596 continuous existence for at least one year if:

3597 (a) the association or its member organizations:

3598 (i) own, control, or hold with power to vote all of the outstanding voting securities of  
3599 an association captive insurance company incorporated as a stock insurer; or

3600 (ii) have complete voting control over an association captive insurance company  
3601 incorporated as a mutual insurer;

3602 (b) the association's member organizations collectively constitute all of the subscribers  
3603 of an association captive insurance company formed as a reciprocal insurer; or

3604 (c) the association or its member organizations have complete voting control over an  
3605 association captive insurance company formed as a limited liability company.

3606 (4) "Association captive insurance company" means a business entity that insures risks  
3607 of:

3608 (a) a member organization of the association;

3609 (b) an affiliate of a member organization of the association; and

3610 (c) the association.

3611 (5) "Branch business" means an insurance business transacted by a branch captive  
3612 insurance company in this state.

3613 (6) "Branch captive insurance company" means an alien captive insurance company  
3614 that has a certificate of authority from the commissioner to transact the business of insurance in  
3615 this state through a captive insurance company that is domiciled outside of this state.

3616 (7) "Branch operation" means a business operation of a branch captive insurance  
3617 company in this state.

3618 (8) "Captive insurance company" means any of the following formed or holding a  
3619 certificate of authority under this chapter:

3620 (a) a branch captive insurance company;

3621 (b) a pure captive insurance company;

- 3622 (c) an association captive insurance company;
- 3623 (d) a sponsored captive insurance company;
- 3624 (e) an industrial insured captive insurance company, including an industrial insured
- 3625 captive insurance company formed as a risk retention group captive in this state pursuant to the
- 3626 provisions of the Federal Liability Risk Retention Act of 1986;
- 3627 (f) a special purpose captive insurance company; or
- 3628 (g) a special purpose financial captive insurance company.
- 3629 (9) "Commissioner" means Utah's Insurance Commissioner or the commissioner's
- 3630 designee.
- 3631 (10) "Common ownership and control" means that two or more captive insurance
- 3632 companies are owned or controlled by the same person or group of persons as follows:
- 3633 (a) in the case of a captive insurance company that is a stock corporation, the direct or
- 3634 indirect ownership of 80% or more of the outstanding voting stock of the stock corporation;
- 3635 (b) in the case of a captive insurance company that is a mutual corporation, the direct
- 3636 or indirect ownership of 80% or more of the surplus and the voting power of the mutual
- 3637 corporation;
- 3638 (c) in the case of a captive insurance company that is a limited liability company, the
- 3639 direct or indirect ownership by the same member or members of 80% or more of the
- 3640 membership interests in the limited liability company; or
- 3641 (d) in the case of a sponsored captive insurance company, a protected cell is a separate
- 3642 captive insurance company owned and controlled by the protected cell's participant, only if:
- 3643 (i) the participant is the only participant with respect to the protected cell; and
- 3644 (ii) the participant is the sponsor or is affiliated with the sponsor of the sponsored
- 3645 captive insurance company through common ownership and control.
- 3646 (11) "Consolidated debt to total capital ratio" means the ratio of Subsection (11)(a) to
- 3647 (b).
- 3648 (a) This Subsection (11)(a) is an amount equal to the sum of all debts and hybrid
- 3649 capital instruments including:
- 3650 (i) all borrowings from depository institutions;
- 3651 (ii) all senior debt;
- 3652 (iii) all subordinated debts;

- 3653 (iv) all trust preferred shares; and
- 3654 (v) all other hybrid capital instruments that are not included in the determination of  
3655 consolidated GAAP net worth issued and outstanding.
- 3656 (b) This Subsection (11)(b) is an amount equal to the sum of:
- 3657 (i) total capital consisting of all debts and hybrid capital instruments as described in  
3658 Subsection (11)(a); and
- 3659 (ii) shareholders' equity determined in accordance with generally accepted accounting  
3660 principles for reporting to the United States Securities and Exchange Commission.
- 3661 (12) "Consolidated GAAP net worth" means the consolidated shareholders' or  
3662 members' equity determined in accordance with generally accepted accounting principles for  
3663 reporting to the United States Securities and Exchange Commission.
- 3664 (13) "Controlled unaffiliated business" means a business entity:
- 3665 (a) (i) in the case of a pure captive insurance company, that is not in the corporate or  
3666 limited liability company system of a parent or the parent's affiliate; or
- 3667 (ii) in the case of an industrial insured captive insurance company, that is not in the  
3668 corporate or limited liability company system of an industrial insured or an affiliated company  
3669 of the industrial insured;
- 3670 (b) (i) in the case of a pure captive insurance company, that has a contractual  
3671 relationship with a parent or affiliate; or
- 3672 (ii) in the case of an industrial insured captive insurance company, that has a  
3673 contractual relationship with an industrial insured or an affiliated company of the industrial  
3674 insured; and
- 3675 (c) whose risks that are or will be insured by a pure captive insurance company, an  
3676 industrial insured captive insurance company, or both are managed [~~by one of the following~~] in  
3677 accordance with Subsection 31A-37-106(1)(j) by:
- 3678 (i) (A) a pure captive insurance company; or
- 3679 [~~(ii)~~] (B) an industrial insured captive insurance company[~~;~~]; or
- 3680 (ii) a parent or affiliate of:
- 3681 (A) a pure captive insurance company; or
- 3682 (B) an industrial insured captive insurance company.
- 3683 (14) "Department" means the Insurance Department.

- 3684 (15) "Industrial insured" means an insured:  
3685 (a) that produces insurance:  
3686 (i) by the services of a full-time employee acting as a risk manager or insurance  
3687 manager; or  
3688 (ii) using the services of a regularly and continuously qualified insurance consultant;  
3689 (b) whose aggregate annual premiums for insurance on all risks total at least \$25,000;  
3690 and  
3691 (c) that has at least 25 full-time employees.
- 3692 (16) "Industrial insured captive insurance company" means a business entity that:  
3693 (a) insures risks of the industrial insureds that comprise the industrial insured group;  
3694 and  
3695 (b) may insure the risks of:  
3696 (i) an affiliated company of an industrial insured; or  
3697 (ii) a controlled unaffiliated business of:  
3698 (A) an industrial insured; or  
3699 (B) an affiliated company of an industrial insured.
- 3700 (17) "Industrial insured group" means:  
3701 (a) a group of industrial insureds that collectively:  
3702 (i) own, control, or hold with power to vote all of the outstanding voting securities of  
3703 an industrial insured captive insurance company incorporated or organized as a limited liability  
3704 company as a stock insurer; or  
3705 (ii) have complete voting control over an industrial insured captive insurance company  
3706 incorporated or organized as a limited liability company as a mutual insurer;  
3707 (b) a group that is:  
3708 (i) created under the Product Liability Risk Retention Act of 1981, 15 U.S.C. Sec. 3901  
3709 et seq., as amended, as a corporation or other limited liability association; and  
3710 (ii) taxable under this title as a:  
3711 (A) stock corporation; or  
3712 (B) mutual insurer; or  
3713 (c) a group that has complete voting control over an industrial captive insurance  
3714 company formed as a limited liability company.



- 3715 (18) "Member organization" means a person that belongs to an association.
- 3716 (19) "Parent" means a person that directly or indirectly owns, controls, or holds with  
3717 power to vote more than 50% of:
- 3718 (a) the outstanding voting securities of a pure captive insurance company; or  
3719 (b) the pure captive insurance company, if the pure captive insurance company is  
3720 formed as a limited liability company.
- 3721 (20) "Participant" means an entity that is insured by a sponsored captive insurance  
3722 company:
- 3723 (a) if the losses of the participant are limited through a participant contract to the assets  
3724 of a protected cell; and
- 3725 (b)(i) the entity is permitted to be a participant under Section 31A-37-403; or  
3726 (ii) the entity is an affiliate of an entity permitted to be a participant under Section  
3727 31A-37-403.
- 3728 (21) "Participant contract" means a contract by which a sponsored captive insurance  
3729 company:
- 3730 (a) insures the risks of a participant; and  
3731 (b) limits the losses of the participant to the assets of a protected cell.
- 3732 (22) "Protected cell" means a separate account established and maintained by a  
3733 sponsored captive insurance company for one participant.
- 3734 (23) "Pure captive insurance company" means a business entity that insures risks of a  
3735 parent or affiliate of the business entity.
- 3736 (24) "Special purpose financial captive insurance company" is as defined in Section  
3737 31A-37a-102.
- 3738 (25) "Sponsor" means an entity that:
- 3739 (a) meets the requirements of Section 31A-37-402; and  
3740 (b) is approved by the commissioner to:
- 3741 (i) provide all or part of the capital and surplus required by applicable law in an amount  
3742 of not less than \$350,000, which amount the commissioner may increase by order if the  
3743 commissioner considers it necessary; and  
3744 (ii) organize and operate a sponsored captive insurance company.
- 3745 (26) "Sponsored captive insurance company" means a captive insurance company:

3746 (a) in which the minimum capital and surplus required by applicable law is provided by  
3747 one or more sponsors;

3748 (b) that is formed or holding a certificate of authority under this chapter;

3749 (c) that insures the risks of a separate participant through the contract; and

3750 (d) that segregates each participant's liability through one or more protected cells.

3751 (27) "Treasury rates" means the United States Treasury strip asked yield as published  
3752 in the Wall Street Journal as of a balance sheet date.

3753 Section 56. Section **31A-37-106** is amended to read:

3754 **31A-37-106. Authority to make rules -- Authority to issue orders.**

3755 (1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
3756 commissioner may adopt rules to:

3757 (a) determine circumstances under which a branch captive insurance company is not  
3758 required to be a pure captive insurance company;

3759 (b) require a statement, document, or information that a captive insurance company  
3760 shall provide to the commissioner to obtain a certificate of authority;

3761 (c) determine a factor a captive insurance company shall provide evidence of under  
3762 Subsection [31A-37-202\(4\)\(~~f~~\)\(b\)](#);

3763 (d) prescribe one or more capital requirements for a captive insurance company in  
3764 addition to those required under Section [31A-37-204](#) based on the type, volume, and nature of  
3765 insurance business transacted by the captive insurance company;

3766 (e) waive or modify a requirement for public notice and hearing for the following by a  
3767 captive insurance company:

3768 (i) merger;

3769 (ii) consolidation;

3770 (iii) conversion;

3771 (iv) mutualization;

3772 (v) redomestication; or

3773 (vi) acquisition;

3774 (f) approve the use of one or more reliable methods of valuation and rating for:

3775 (i) an association captive insurance company;

3776 (ii) a sponsored captive insurance company; or

- 3777 (iii) an industrial insured group;
- 3778 (g) prohibit or limit an investment that threatens the solvency or liquidity of:
- 3779 (i) a pure captive insurance company; or
- 3780 (ii) an industrial insured captive insurance company;
- 3781 (h) determine the financial reports a sponsored captive insurance company shall
- 3782 annually file with the commissioner;
- 3783 (i) prescribe the required forms and reports under Section 31A-37-501; and
- 3784 (j) establish one or more standards to ensure that:
- 3785 (i) one of the following is able to exercise control of the risk management function of a
- 3786 controlled unaffiliated business to be insured by a pure captive insurance company:
- 3787 (A) a parent; or
- 3788 (B) an affiliated company of a parent; or
- 3789 (ii) one of the following is able to exercise control of the risk management function of
- 3790 a controlled unaffiliated business to be insured by an industrial insured captive insurance
- 3791 company:
- 3792 (A) an industrial insured; or
- 3793 (B) an affiliated company of the industrial insured.
- 3794 (2) Notwithstanding Subsection (1)(j), until the commissioner adopts the rules
- 3795 authorized under Subsection (1)(j), the commissioner may by temporary order grant authority
- 3796 to insure risks to:
- 3797 (a) a pure captive insurance company; or
- 3798 (b) an industrial insured captive insurance company.
- 3799 (3) The commissioner may issue prohibitory, mandatory, and other orders relating to a
- 3800 captive insurance company as necessary to enable the commissioner to secure compliance with
- 3801 this chapter.
- 3802 Section 57. Section 31A-37-202 is amended to read:
- 3803 **31A-37-202. Permissive areas of insurance.**
- 3804 (1) (a) Except as provided in Subsection (1)(b), when permitted by its articles of
- 3805 incorporation, certificate of organization, or charter, a captive insurance company may apply to
- 3806 the commissioner for a certificate of authority to do all insurance authorized by this title except
- 3807 workers' compensation insurance.

- 3808 (b) Notwithstanding Subsection (1)(a):
- 3809 (i) a pure captive insurance company may not insure a risk other than a risk of:
- 3810 (A) ~~[its]~~ the pure captive insurance company's parent or affiliate;
- 3811 (B) a controlled unaffiliated business; or
- 3812 (C) a combination of Subsections (1)(b)(i)(A) and (B);
- 3813 (ii) an association captive insurance company may not insure a risk other than a risk of:
- 3814 (A) an affiliate;
- 3815 (B) a member organization of its association; and
- 3816 (C) an affiliate of a member organization of its association;
- 3817 (iii) an industrial insured captive insurance company may not insure a risk other than a
- 3818 risk of:
- 3819 (A) an industrial insured that is part of the industrial insured group;
- 3820 (B) an affiliate of an industrial insured that is part of the industrial insured group; and
- 3821 (C) a controlled unaffiliated business of:
- 3822 (I) an industrial insured that is part of the industrial insured group; or
- 3823 (II) an affiliate of an industrial insured that is part of the industrial insured group;
- 3824 (iv) a special purpose captive insurance company may only insure a risk of its parent;
- 3825 (v) a captive insurance company may not provide:
- 3826 (A) personal motor vehicle insurance coverage;
- 3827 (B) homeowner's insurance coverage; or
- 3828 (C) a component of a coverage described in this Subsection (1)(b)(v); and
- 3829 (vi) a captive insurance company may not accept or cede reinsurance except as
- 3830 provided in Section [31A-37-303](#).
- 3831 (c) Notwithstanding Subsection (1)(b)(iv), for a risk approved by the commissioner a
- 3832 special purpose captive insurance company may provide:
- 3833 (i) insurance;
- 3834 (ii) reinsurance; or
- 3835 (iii) both insurance and reinsurance.
- 3836 (2) To conduct insurance business in this state a captive insurance company shall:
- 3837 (a) obtain from the commissioner a certificate of authority authorizing it to conduct
- 3838 insurance business in this state;

- 3839 (b) hold at least once each year in this state:
- 3840 (i) a board of directors meeting; or
- 3841 [~~(ii) in the case of a reciprocal insurer, a subscriber's advisory committee meeting; or~~]
- 3842 [~~(iii)~~] (ii) in the case of a limited liability company, a meeting of the managers;
- 3843 (c) maintain in this state:
- 3844 (i) the principal place of business of the captive insurance company; or
- 3845 (ii) in the case of a branch captive insurance company, the principal place of business
- 3846 for the branch operations of the branch captive insurance company; and
- 3847 (d) except as provided in Subsection (3), appoint a resident registered agent to accept
- 3848 service of process and to otherwise act on behalf of the captive insurance company in this state.
- 3849 (3) Notwithstanding Subsection (2)(d), in the case of a captive insurance company
- 3850 formed as a corporation [~~or a reciprocal insurer~~], if the registered agent cannot with reasonable
- 3851 diligence be found at the registered office of the captive insurance company, the commissioner
- 3852 is the agent of the captive insurance company upon whom process, notice, or demand may be
- 3853 served.
- 3854 (4) (a) Before receiving a certificate of authority, a captive insurance company:
- 3855 (i) formed as a corporation shall file with the commissioner:
- 3856 (A) a certified copy of:
- 3857 (I) articles of incorporation or the charter of the corporation; and
- 3858 (II) bylaws of the corporation;
- 3859 (B) a statement under oath of the president and secretary of the corporation showing
- 3860 the financial condition of the corporation; and
- 3861 (C) any other statement or document required by the commissioner under Section
- 3862 [31A-37-106](#); and
- 3863 [~~(ii) formed as a reciprocal shall;~~]
- 3864 [~~(A) file with the commissioner;~~]
- 3865 [~~(I) a certified copy of the power of attorney of the attorney-in-fact of the reciprocal;~~]
- 3866 [~~(II) a certified copy of the subscribers' agreement of the reciprocal;~~]
- 3867 [~~(III) a statement under oath of the attorney-in-fact of the reciprocal showing the~~
- 3868 ~~financial condition of the reciprocal; and]~~
- 3869 [~~(IV) any other statement or document required by the commissioner under Section~~

3870 ~~31A-37-106; and]~~  
3871 ~~[(B) submit to the commissioner for approval a description of the:]~~  
3872 ~~[(F) coverages;]~~  
3873 ~~[(H) deductibles;]~~  
3874 ~~[(III) coverage limits;]~~  
3875 ~~[(IV) rates; and]~~  
3876 ~~[(V) any other information the commissioner requires under Section 31A-37-106; and]~~  
3877 ~~[(iii)]~~ (ii) formed as a limited liability company shall file with the commissioner:  
3878 (A) a certified copy of the certificate of organization and the operating agreement of  
3879 the organization;  
3880 (B) a statement under oath of the president and secretary of the organization showing  
3881 the financial condition of the organization;  
3882 (C) evidence that the limited liability company is manager-managed; and  
3883 (D) any other statement or document required by the commissioner under Section  
3884 31A-37-106.  
3885 ~~[(b)(i) If there is a subsequent material change in an item in the description required~~  
3886 ~~under Subsection (4)(a)(ii)(B) for a reciprocal captive insurance company, the reciprocal~~  
3887 ~~captive insurance company shall submit to the commissioner for approval an appropriate~~  
3888 ~~revision to the description required under Subsection (4)(a)(ii)(B).]~~  
3889 ~~[(ii) A reciprocal captive insurance company that is required to submit a revision under~~  
3890 ~~Subsection (4)(b)(i) may not offer any additional types of insurance until the commissioner~~  
3891 ~~approves a revision of the description.]~~  
3892 ~~[(iii) A reciprocal captive insurance company shall inform the commissioner of a~~  
3893 ~~material change in a rate within 30 days of the adoption of the change.]~~  
3894 ~~[(c)]~~ (b) In addition to the information required by Subsection (4)(a), an applicant  
3895 captive insurance company shall file with the commissioner evidence of:  
3896 (i) the amount and liquidity of the assets of the applicant captive insurance company  
3897 relative to the risks to be assumed by the applicant captive insurance company;  
3898 (ii) the adequacy of the expertise, experience, and character of the person who will  
3899 manage the applicant captive insurance company;  
3900 (iii) the overall soundness of the plan of operation of the applicant captive insurance

3901 company;

3902 (iv) the adequacy of the loss prevention programs for the following of the applicant

3903 captive insurance company:

3904 (A) a parent;

3905 (B) a member organization; or

3906 (C) an industrial insured; and

3907 (v) any other factor the commissioner:

3908 (A) adopts by rule under Section 31A-37-106; and

3909 (B) considers relevant in ascertaining whether the applicant captive insurance company

3910 will be able to meet the policy obligations of the applicant captive insurance company.

3911 [~~(d)~~] (c) In addition to the information required by Subsections (4)(a)[~~;~~] and (b)[~~;~~ and

3912 (~~e~~)]; an applicant sponsored captive insurance company shall file with the commissioner:

3913 (i) a business plan at the level of detail required by the commissioner under Section

3914 31A-37-106 demonstrating:

3915 (A) the manner in which the applicant sponsored captive insurance company will

3916 account for the losses and expenses of each protected cell; and

3917 (B) the manner in which the applicant sponsored captive insurance company will report

3918 to the commissioner the financial history, including losses and expenses, of each protected cell;

3919 (ii) a statement acknowledging that the applicant sponsored captive insurance company

3920 will make all financial records of the applicant sponsored captive insurance company,

3921 including records pertaining to a protected cell, available for inspection or examination by the

3922 commissioner;

3923 (iii) a contract or sample contract between the applicant sponsored captive insurance

3924 company and a participant; and

3925 (iv) evidence that expenses will be allocated to each protected cell in an equitable

3926 manner.

3927 (5) (a) Information submitted pursuant to Subsection (4) is classified as a protected

3928 record under Title 63G, Chapter 2, Government Records Access and Management Act.

3929 (b) Notwithstanding Title 63G, Chapter 2, Government Records Access and

3930 Management Act, the commissioner may disclose information submitted pursuant to

3931 Subsection (4) to a public official having jurisdiction over the regulation of insurance in

3932 another state if:

3933 (i) the public official receiving the information agrees in writing to maintain the  
3934 confidentiality of the information; and

3935 (ii) the laws of the state in which the public official serves require the information to be  
3936 confidential.

3937 (c) This Subsection (5) does not apply to information provided by an industrial insured  
3938 captive insurance company insuring the risks of an industrial insured group.

3939 (6) (a) A captive insurance company shall pay to the department the following  
3940 nonrefundable fees established by the department under Sections 31A-3-103, 31A-3-304, and  
3941 63J-1-504:

3942 (i) a fee for examining, investigating, and processing, by a department employee, of an  
3943 application for a certificate of authority made by a captive insurance company;

3944 (ii) a fee for obtaining a certificate of authority for the year the captive insurance  
3945 company is issued a certificate of authority by the department; and

3946 (iii) a certificate of authority renewal fee.

3947 (b) The commissioner may:

3948 (i) assign a department employee or retain legal, financial, and examination services  
3949 from outside the department to perform the services described in:

3950 (A) Subsection (6)(a); and

3951 (B) Section 31A-37-502; and

3952 (ii) charge the reasonable cost of services described in Subsection (6)(b)(i) to the  
3953 applicant captive insurance company.

3954 (7) If the commissioner is satisfied that the documents and statements filed by the  
3955 applicant captive insurance company comply with this chapter, the commissioner may grant a  
3956 certificate of authority authorizing the company to do insurance business in this state.

3957 (8) A certificate of authority granted under this section expires annually and shall be  
3958 renewed by July 1 of each year.

3959 Section 58. Section 31A-37-204 is amended to read:

3960 **31A-37-204. Paid-in capital -- Other capital.**

3961 (1) (a) The commissioner may not issue a certificate of authority to a company  
3962 described in Subsection (1)(c) unless the company possesses and thereafter maintains



- 3963 unimpaired paid-in capital and unimpaired paid-in surplus of:
- 3964 (i) in the case of a pure captive insurance company, not less than \$250,000;
- 3965 (ii) in the case of an association captive insurance company [~~incorporated as a stock~~
- 3966 ~~insurer~~], not less than \$750,000;
- 3967 (iii) in the case of an industrial insured captive insurance company incorporated as a
- 3968 stock insurer, not less than \$700,000;
- 3969 (iv) in the case of a sponsored captive insurance company, not less than \$1,000,000, of
- 3970 which a minimum of \$350,000 is provided by the sponsor; or
- 3971 (v) in the case of a special purpose captive insurance company, an amount determined
- 3972 by the commissioner after giving due consideration to the company's business plan, feasibility
- 3973 study, and pro-formas, including the nature of the risks to be insured.
- 3974 (b) The paid-in capital and surplus required under this Subsection (1) may be in the
- 3975 form of:
- 3976 (i) (A) cash; or
- 3977 (B) cash equivalent;
- 3978 (ii) an irrevocable letter of credit:
- 3979 (A) issued by:
- 3980 (I) a bank chartered by this state; or
- 3981 (II) a member bank of the Federal Reserve System; and
- 3982 (B) approved by the commissioner; [~~or~~]
- 3983 (iii) marketable securities as determined by [~~Subsections 31A-18-105(1) and (6):~~]
- 3984 Subsection (5); or
- 3985 (iv) some other thing of value approved by the commissioner, for a period not to
- 3986 exceed 45 days, to facilitate the formation of a captive insurance company in this state pursuant
- 3987 to an approved plan of liquidation and reorganization of another captive insurance company or
- 3988 alien captive insurance company in another jurisdiction.
- 3989 (c) This Subsection (1) applies to:
- 3990 (i) a pure captive insurance company;
- 3991 (ii) a sponsored captive insurance company;
- 3992 (iii) a special purpose captive insurance company;
- 3993 (iv) an association captive insurance company [~~incorporated as a stock insurer~~]; or

3994 (v) an industrial insured captive insurance company [~~incorporated as a stock insurer~~].

3995 (2) (a) The commissioner may, under Section 31A-37-106, prescribe additional capital  
3996 based on the type, volume, and nature of insurance business transacted.

3997 (b) The capital prescribed by the commissioner under this Subsection (2) may be in the  
3998 form of:

3999 (i) cash;

4000 (ii) an irrevocable letter of credit issued by:

4001 (A) a bank chartered by this state; or

4002 (B) a member bank of the Federal Reserve System; or

4003 (iii) marketable securities as determined by [~~Subsections 31A-18-105(1) and (6)~~]

4004 Subsection (5).

4005 (3) (a) Except as provided in Subsection (3)(c), a branch captive insurance company, as  
4006 security for the payment of liabilities attributable to branch operations, shall, through its branch  
4007 operations, establish and maintain a trust fund:

4008 (i) funded by an irrevocable letter of credit or other acceptable asset; and

4009 (ii) in the United States for the benefit of:

4010 (A) United States policyholders; and

4011 (B) United States ceding insurers under:

4012 (I) insurance policies issued; or

4013 (II) reinsurance contracts issued or assumed.

4014 (b) The amount of the security required under this Subsection (3) shall be no less than:

4015 (i) the capital and surplus required by this chapter; and

4016 (ii) the reserves on the insurance policies or reinsurance contracts, including:

4017 (A) reserves for losses;

4018 (B) allocated loss adjustment expenses;

4019 (C) incurred but not reported losses; and

4020 (D) unearned premiums with regard to business written through branch operations.

4021 (c) Notwithstanding the other provisions of this Subsection (3)~~];~~

4022 (i) the commissioner may permit a branch captive insurance company that is required  
4023 to post security for loss reserves on branch business by its reinsurer to reduce the funds in the  
4024 trust account required by this section by the same amount as the security posted if the security

4025 remains posted with the reinsurer[-]; and

4026 (ii) a branch captive insurance company that is the result of the licensure of an alien  
4027 captive insurance company that is not formed in an alien jurisdiction is not subject to the  
4028 requirements of this Subsection (3).

4029 (4) (a) A captive insurance company may not pay the following without the prior  
4030 approval of the commissioner:

4031 (i) a dividend out of capital or surplus in excess of the limits under Section  
4032 16-10a-640; or

4033 (ii) a distribution with respect to capital or surplus in excess of the limits under Section  
4034 16-10a-640.

4035 (b) The commissioner shall condition approval of an ongoing plan for the payment of  
4036 dividends or other distributions on the retention, at the time of each payment, of capital or  
4037 surplus in excess of:

4038 (i) amounts specified by the commissioner under Section 31A-37-106; or

4039 (ii) determined in accordance with formulas approved by the commissioner under  
4040 Section 31A-37-106.

4041 ~~[(5) Notwithstanding Subsection (1), a captive insurance company organized as a~~  
4042 ~~reciprocal insurer under this chapter may not be issued a certificate of authority unless the~~  
4043 ~~captive insurance company possesses and maintains unimpaired paid-in surplus of \$1,000,000.]~~

4044 ~~[(6) (a) The commissioner may prescribe additional unimpaired paid-in surplus based~~  
4045 ~~upon the type, volume, and nature of the insurance business transacted.]~~

4046 ~~[(b) The unimpaired paid-in surplus required under this Subsection (6) may be in the~~  
4047 ~~form of an irrevocable letter of credit issued by:]~~

4048 ~~[(i) a bank chartered by this state; or]~~

4049 ~~[(ii) a member bank of the Federal Reserve System.]~~

4050 (5) For purposes of this section, marketable securities means:

4051 (a) a bond or other evidence of indebtedness of a governmental unit in the United  
4052 States or Canada or any instrumentality of the United States or Canada; or

4053 (b) securities:

4054 (i) traded on one or more of the following exchanges in the United States:

4055 (A) New York;

- 4056 (B) American; or
- 4057 (C) NASDAQ;
- 4058 (ii) when no particular security, or a substantially related security, applied toward the
- 4059 required minimum capital and surplus requirement of Subsection (1) represents more than 50%
- 4060 of the minimum capital and surplus requirement; and
- 4061 (iii) when no group of up to four particular securities, consolidating substantially
- 4062 related securities, applied toward the required minimum capital and surplus requirement of
- 4063 Subsection (1) represents more than 90% of the minimum capital and surplus requirement.
- 4064 (6) Notwithstanding Subsection (5), to protect the solvency and liquidity of a captive
- 4065 insurance company, the commissioner may reject the application of specific assets or amounts
- 4066 of specific assets to satisfying the requirement of Subsection (1).

4067 Section 59. Section **31A-37-301** is amended to read:

4068 **31A-37-301. Formation.**

4069 (1) A pure captive insurance company or a sponsored captive insurance company  
4070 formed as a stock insurer shall be incorporated as a stock insurer with the capital of the pure  
4071 captive insurance company or sponsored captive insurance company:

4072 (a) divided into shares; and

4073 (b) held by the stockholders of the pure captive insurance company or sponsored  
4074 captive insurance company.

4075 (2) A pure captive insurance company or a sponsored captive insurance company  
4076 formed as a limited liability company shall be organized as a members' interest insurer with the  
4077 capital of the pure captive insurance company or sponsored captive insurance company:

4078 (a) divided into interests; and

4079 (b) held by the members of the pure captive insurance company or sponsored captive  
4080 insurance company.

4081 (3) An association captive insurance company or an industrial insured captive  
4082 insurance company may be:

4083 (a) incorporated as a stock insurer with the capital of the association captive insurance  
4084 company or industrial insured captive insurance company:

4085 (i) divided into shares; and

4086 (ii) held by the stockholders of the association captive insurance company or industrial

4087 insured captive insurance company;

4088 (b) incorporated as a mutual insurer without capital stock, with a governing body

4089 elected by the member organizations of the association captive insurance company or industrial

4090 insured captive insurance company; or

4091 ~~[(c) organized as a reciprocal.]~~

4092 (c) organized as a limited liability company with the capital of the association captive

4093 insurance company or industrial insured captive insurance company:

4094 (i) divided into interests; and

4095 (ii) held by the members of the association captive insurance company or industrial

4096 insured captive insurance company.

4097 (4) A captive insurance company formed as a corporation may not have fewer than

4098 three incorporators of whom one shall be a resident of this state.

4099 (5) A captive insurance company formed as a limited liability company may not have

4100 fewer than three organizers of whom one shall be a resident of this state.

4101 (6) (a) Before a captive insurance company formed as a corporation files the

4102 corporation's articles of incorporation with the Division of Corporations and Commercial

4103 Code, the incorporators shall obtain from the commissioner a certificate finding that the

4104 establishment and maintenance of the proposed corporation will promote the general good of

4105 the state.

4106 (b) In considering a request for a certificate under Subsection (6)(a), the commissioner

4107 shall consider:

4108 (i) the character, reputation, financial standing, and purposes of the incorporators;

4109 (ii) the character, reputation, financial responsibility, insurance experience, and

4110 business qualifications of the officers and directors;

4111 (iii) any information in:

4112 (A) the application for a certificate of authority; or

4113 (B) the department's files; and

4114 (iv) other aspects that the commissioner considers advisable.

4115 (7) (a) Before a captive insurance company formed as a limited liability company files

4116 the limited liability company's certificate of organization with the Division of Corporations and

4117 Commercial Code, the limited liability company shall obtain from the commissioner a

4118 certificate finding that the establishment and maintenance of the proposed limited liability  
4119 company will promote the general good of the state.

4120 (b) In considering a request for a certificate under Subsection (7)(a), the commissioner  
4121 shall consider:

4122 (i) the character, reputation, financial standing, and purposes of the organizers;

4123 (ii) the character, reputation, financial responsibility, insurance experience, and  
4124 business qualifications of the managers;

4125 (iii) any information in:

4126 (A) the application for a certificate of authority; or

4127 (B) the department's files; and

4128 (iv) other aspects that the commissioner considers advisable.

4129 (8) (a) A captive insurance company formed as a corporation shall file with the  
4130 Division of Corporations and Commercial Code:

4131 (i) the captive insurance company's articles of incorporation;

4132 (ii) the certificate issued pursuant to Subsection (6); and

4133 (iii) the fees required by the Division of Corporations and Commercial Code.

4134 (b) The Division of Corporations and Commercial Code shall file both the articles of  
4135 incorporation and the certificate described in Subsection (6) for a captive insurance company  
4136 that complies with this section.

4137 (9) (a) A captive insurance company formed as a limited liability company shall file  
4138 with the Division of Corporations and Commercial Code:

4139 (i) the captive insurance company's certificate of organization;

4140 (ii) the certificate issued pursuant to Subsection (7); and

4141 (iii) the fees required by the Division of Corporations and Commercial Code.

4142 (b) The Division of Corporations and Commercial Code shall file both the certificate  
4143 of organization and the certificate described in Subsection (7) for a captive insurance company  
4144 that complies with this section.

4145 (10) (a) The organizers of a captive insurance company formed as a reciprocal insurer  
4146 shall obtain from the commissioner a certificate finding that the establishment and maintenance  
4147 of the proposed association will promote the general good of the state.

4148 (b) In considering a request for a certificate under Subsection (10)(a), the

4149 commissioner shall consider:

4150 (i) the character, reputation, financial standing, and purposes of the incorporators;

4151 (ii) the character, reputation, financial responsibility, insurance experience, and  
4152 business qualifications of the officers and directors;

4153 (iii) any information in:

4154 (A) the application for a certificate of authority; or

4155 (B) the department's files; and

4156 (iv) other aspects that the commissioner considers advisable.

4157 (11) (a) An alien captive insurance company that has received a certificate of authority  
4158 to act as a branch captive insurance company shall obtain from the commissioner a certificate  
4159 finding that:

4160 (i) the home [state] jurisdiction of the alien captive insurance company imposes  
4161 statutory or regulatory standards in a form acceptable to the commissioner on companies  
4162 transacting the business of insurance in that state; and

4163 (ii) after considering the character, reputation, financial responsibility, insurance  
4164 experience, and business qualifications of the officers and directors of the alien captive  
4165 insurance company, and other relevant information, the establishment and maintenance of the  
4166 branch operations will promote the general good of the state.

4167 (b) After the commissioner issues a certificate under Subsection (11)(a) to an alien  
4168 captive insurance company, the alien captive insurance company may register to do business in  
4169 this state.

4170 (12) At least one of the members of the board of directors of a captive insurance  
4171 company formed as a corporation shall be a resident of this state.

4172 (13) At least one of the managers of a limited liability company shall be a resident of  
4173 this state.

4174 ~~[(14) At least one of the members of the subscribers' advisory committee of a captive  
4175 insurance company formed as a reciprocal insurer shall be a resident of this state.]~~

4176 ~~[(15)]~~ (14) (a) A captive insurance company formed as a corporation under this chapter  
4177 has the privileges and is subject to the provisions of the general corporation law as well as the  
4178 applicable provisions contained in this chapter.

4179 (b) If a conflict exists between a provision of the general corporation law and a

4180 provision of this chapter, this chapter shall control.

4181 (c) Except as provided in Subsection ~~[(15)]~~ (14)(d), the provisions of this title  
4182 pertaining to a merger, consolidation, conversion, mutualization, and redomestication apply in  
4183 determining the procedures to be followed by a captive insurance company in carrying out any  
4184 of the transactions described in those provisions.

4185 (d) Notwithstanding Subsection ~~[(15)]~~ (14)(c), the commissioner may waive or modify  
4186 the requirements for public notice and hearing in accordance with rules adopted under Section  
4187 [31A-37-106](#).

4188 (e) If a notice of public hearing is required, but no one requests a hearing, the  
4189 commissioner may cancel the public hearing.

4190 ~~[(16)]~~ (15) (a) A captive insurance company formed as a limited liability company  
4191 under this chapter has the privileges and is subject to ~~[Title 48, Chapter 2c, Utah Revised~~  
4192 ~~Limited Liability Company Act, or]~~ Title 48, Chapter 3a, Utah Revised Uniform Limited  
4193 Liability Company Act~~[, as appropriate pursuant to Section ~~48-3a-1405~~],~~ as well as the  
4194 applicable provisions in this chapter.

4195 (b) If a conflict exists between a provision of the limited liability company law and a  
4196 provision of this chapter, this chapter controls.

4197 (c) The provisions of this title pertaining to a merger, consolidation, conversion,  
4198 mutualization, and redomestication apply in determining the procedures to be followed by a  
4199 captive insurance company in carrying out any of the transactions described in those  
4200 provisions.

4201 (d) Notwithstanding Subsection ~~[(16)]~~ (15)(c), the commissioner may waive or modify  
4202 the requirements for public notice and hearing in accordance with rules adopted under Section  
4203 [31A-37-106](#).

4204 (e) If a notice of public hearing is required, but no one requests a hearing, the  
4205 commissioner may cancel the public hearing.

4206 ~~[(17) (a) A captive insurance company formed as a reciprocal insurer under this chapter~~  
4207 ~~has the powers set forth in Section [31A-4-114](#) in addition to the applicable provisions of this~~  
4208 ~~chapter.]~~

4209 ~~[(b) If a conflict exists between the provisions of Section [31A-4-114](#) and the provisions~~  
4210 ~~of this chapter with respect to a captive insurance company, this chapter shall control.]~~



4211 ~~[(c) To the extent a reciprocal insurer is made subject to other provisions of this title~~  
4212 ~~pursuant to Section 31A-14-208, the provisions are not applicable to a reciprocal insurer~~  
4213 ~~formed under this chapter unless the provisions are expressly made applicable to a captive~~  
4214 ~~insurance company under this chapter.]~~

4215 ~~[(d) In addition to the provisions of this Subsection (17), a captive insurance company~~  
4216 ~~organized as a reciprocal insurer that is an industrial insured group has the privileges of Section~~  
4217 ~~31A-4-114 in addition to applicable provisions of this title.]~~

4218 ~~[(18)]~~ (16) (a) The articles of incorporation or bylaws of a captive insurance company  
4219 formed as a corporation may not authorize a quorum of a board of directors to consist of fewer  
4220 than one-third of the fixed or prescribed number of directors as provided in Section  
4221 16-10a-824.

4222 (b) The certificate of organization of a captive insurance company formed as a limited  
4223 liability company may not authorize a quorum of a board of managers to consist of fewer than  
4224 one-third of the fixed or prescribed number of directors required in Section 16-10a-824.

4225 Section 60. Section 31A-37-303 is amended to read:

4226 **31A-37-303. Reinsurance.**

4227 (1) A captive insurance company may cede risks to any insurance company approved  
4228 by the commissioner. A captive insurance company may provide reinsurance, as authorized in  
4229 this title, on risks ceded for the benefit of a parent, affiliate, or controlled unaffiliated business.

4230 (2) (a) A captive insurance company may take credit for reserves on risks or portions of  
4231 risks ceded to reinsurers if the captive insurance company complies with Section 31A-17-404,  
4232 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or if the captive insurance company complies  
4233 with other requirements as the commissioner may establish by rule made in accordance with  
4234 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4235 (b) Unless the reinsurer is in compliance with Section 31A-17-404, 31A-17-404.1,  
4236 31A-17-404.3, or 31A-17-404.4 or a rule adopted under Subsection (2)(a), a captive insurance  
4237 company may not take credit for:

4238 (i) reserves on risks ceded to a reinsurer; or

4239 (ii) portions of risks ceded to a reinsurer.

4240 Section 61. Section 31A-37-305 is amended to read:

4241 **31A-37-305. Contributions to guaranty or insolvency fund prohibited.**

4242 (1) A captive insurance company[~~, including a captive insurance company organized as~~  
 4243 ~~a reciprocal insurer under this chapter,~~] may not join or contribute financially to any of the  
 4244 following in this state:

- 4245 (a) a plan;
- 4246 (b) a pool;
- 4247 (c) an association;
- 4248 (d) a guaranty fund; or
- 4249 (e) an insolvency fund.

4250 (2) A captive insurance company, the insured of a captive insurance company, the  
 4251 parent of a captive insurance company, an affiliate of a captive insurance company, or a  
 4252 member organization of an association captive insurance company[~~, or in the case of a captive~~  
 4253 ~~insurance company organized as a reciprocal insurer, a subscriber of the captive insurance~~  
 4254 ~~company,~~] may not receive a benefit from:

- 4255 (a) a plan;
- 4256 (b) a pool;
- 4257 (c) an association;
- 4258 (d) a guaranty fund for claims arising out of the operations of the captive insurance  
 4259 company; or
- 4260 (e) an insolvency fund for claims arising out of the operations of the captive insurance  
 4261 company.

4262 Section 62. Section ~~31A-42-201~~ is amended to read:

4263 **31A-42-201. Creation of risk adjuster mechanism -- Board of directors --**  
 4264 **Appointment -- Terms -- Quorum -- Plan preparation.**

4265 (1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity  
 4266 within the department.

4267 (2) (a) The risk adjuster is under the direction of a board of directors composed of up to  
 4268 nine members described in Subsection (2)(b).

4269 (b) The board of directors shall consist of:

4270 (i) the following directors appointed by the governor with the consent of the Senate:

4271 (A) at least [~~three~~] one, but up to five, directors with actuarial experience who  
 4272 represent insurers[~~(-f)~~] that are participating or have committed to participate in the defined

4273 contribution arrangement market in the state; [and]  
4274 [~~(H) including at least one and up to two directors who represent an insurer that has a~~  
4275 ~~small percentage of lives in the defined contribution market;]~~  
4276 (B) one director who represents either an individual employee or employer; and  
4277 (C) one director who represents the Office of Consumer Health Services within the  
4278 Governor's Office of Economic Development;  
4279 (ii) one director representing the Public Employees' Benefit and Insurance Program  
4280 with actuarial experience, appointed by the director of the Public Employees' Benefit and  
4281 Insurance Program; and  
4282 (iii) the commissioner, or a representative of the commissioner who:  
4283 (A) is appointed by the commissioner; and  
4284 (B) has actuarial experience.  
4285 (c) The commissioner, or a representative appointed by the commissioner may vote  
4286 only in the event of a tie vote.  
4287 (3) (a) Except as required by Subsection (3)(b), as terms of current board members  
4288 appointed by the governor expire, the governor shall appoint each new member or reappointed  
4289 member to a four-year term.  
4290 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the  
4291 time of appointment or reappointment, adjust the length of terms to ensure that the terms of  
4292 board members are staggered so that approximately half of the board is appointed every two  
4293 years.  
4294 (c) Notwithstanding the requirements of Subsection (3)(a), a board member shall  
4295 continue to serve until the board member is reappointed or replaced by another individual in  
4296 accordance with this section.  
4297 (4) When a vacancy occurs in the membership for any reason, the replacement shall be  
4298 appointed for the unexpired term in the same manner as the original appointment was made.  
4299 (5) (a) A board member who is not a government employee may not receive  
4300 compensation or benefits for the board member's services.  
4301 (b) A state government member who is a board member because of the board member's  
4302 state government position may not receive per diem or expenses for the member's service.  
4303 (6) The board shall elect annually a chair and vice chair from its membership.

4304 (7) A majority of the board members is a quorum for the transaction of business.

4305 (8) The action of a majority of the members of the quorum is the action of the board.

4306 Section 63. Section **31A-44-603** is amended to read:

4307 **31A-44-603. Examinations.**

4308 (1) The department may conduct periodic on-site examinations of a provider.

4309 (2) In conducting an examination, the department or the department's staff:

4310 (a) shall have full and free access to all the provider's records; and

4311 (b) may summon and qualify as a witness, under oath, and examine, any director,  
4312 officer, member, agent, or employee of the provider, and any other person, concerning the  
4313 condition and affairs of the provider or a facility.

4314 (3) Books and records shall be kept for not less than three calendar years in addition to  
4315 the current calendar year.

4316 [~~3~~] (4) The provider shall pay the reasonable costs of an examination under this  
4317 section.

4318 [~~4~~] (5) The department may conduct an on-site examination in conjunction with an  
4319 examination performed by a representative of an agency of another state.

4320 [~~5~~] (6) (a) The department, in lieu of an on-site examination, may accept the  
4321 examination report of an agency of another state that has regulatory oversight of the provider,  
4322 or a report prepared by an independent accounting firm.

4323 (b) A report accepted under Subsection [~~5~~] (6)(a) is considered for all purposes an  
4324 official report of the department.

4325 [~~6~~] (7) Upon reasonable cause, the department may conduct an on-site examination of  
4326 an unlicensed person to determine whether a violation of this chapter has occurred.

4327 Section 64. Section **53-2a-1102** is amended to read:

4328 **53-2a-1102. Search and Rescue Financial Assistance Program -- Uses --**  
4329 **Rulemaking -- Distribution.**

4330 (1) (a) "Assistance card program" means the Utah Search and Rescue Assistance Card  
4331 Program created within this section.

4332 (b) "Card" means the Search and Rescue Assistance Card issued under this section to a  
4333 participant.

4334 (c) "Participant" means an individual, family, or group who is registered pursuant to

4335 this section as having a valid card at the time search, rescue, or both are provided.

4336 (d) "Program" means the Search and Rescue Financial Assistance Program created  
4337 within this section.

4338 (e) (i) "Reimbursable expenses," as used in this section, means those reasonable  
4339 expenses incidental to search and rescue activities.

4340 (ii) "Reimbursable expenses" include:

4341 (A) rental for fixed wing aircraft, helicopters, snowmobiles, boats, and generators;

4342 (B) replacement and upgrade of search and rescue equipment;

4343 (C) training of search and rescue volunteers;

4344 (D) costs of providing workers' compensation benefits for volunteer search and rescue  
4345 team members under Section 67-20-7.5; and

4346 (E) any other equipment or expenses necessary or appropriate for conducting search  
4347 and rescue activities.

4348 (iii) "Reimbursable expenses" do not include any salary or overtime paid to any person  
4349 on a regular or permanent payroll, including permanent part-time employees of any agency of  
4350 the state.

4351 (f) "Rescue" means search services, rescue services, or both search and rescue services.

4352 (2) There is created the Search and Rescue Financial Assistance Program within the  
4353 division.

4354 (3) (a) The program shall be funded from the following revenue sources:

4355 (i) any voluntary contributions to the state received for search and rescue operations;

4356 (ii) money received by the state under Subsection (11) and under Sections 23-19-42,  
4357 41-22-34, and 73-18-24; and

4358 (iii) appropriations made to the program by the Legislature.

4359 (b) All money received from the revenue sources in Subsections (3)(a)(i) and (ii) shall  
4360 be deposited into the General Fund as a dedicated credit to be used solely for the purposes  
4361 under this section.

4362 (c) All funding for the program is nonlapsing.

4363 (4) The director shall use the money to reimburse counties for all or a portion of each  
4364 county's reimbursable expenses for search and rescue operations, subject to:

4365 (a) the approval of the Search and Rescue Advisory Board as provided in Section

4366 53-2a-1104;

4367 (b) money available in the program; and

4368 (c) rules made under Subsection (7).

4369 (5) Program money may not be used to reimburse for any paid personnel costs or paid  
4370 man hours spent in emergency response and search and rescue related activities.

4371 (6) The Legislature finds that these funds are for a general and statewide public  
4372 purpose.

4373 (7) The division, with the approval of the Search and Rescue Advisory Board, shall  
4374 make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and  
4375 consistent with this section:

4376 (a) specifying the costs that qualify as reimbursable expenses;

4377 (b) defining the procedures of counties to submit expenses and be reimbursed;

4378 (c) defining a participant in the assistance card program, including:

4379 (i) individuals; and

4380 (ii) families and organized groups who qualify as participants;

4381 (d) defining the procedure for issuing a card to a participant;

4382 (e) defining excluded expenses that may not be reimbursed under the program,  
4383 including medical expenses;

4384 (f) establishing the card renewal cycle for the Utah Search and Rescue Assistance Card  
4385 Program;

4386 (g) establishing the frequency of review of the fee schedule;

4387 (h) providing for the administration of the program; and

4388 (i) providing a formula to govern the distribution of available money among the  
4389 counties for uncompensated search and rescue expenses based on:

4390 (i) the total qualifying expenses submitted;

4391 (ii) the number of search and rescue incidents per county population;

4392 (iii) the number of victims that reside outside the county; and

4393 (iv) the number of volunteer hours spent in each county in emergency response and  
4394 search and rescue related activities per county population.

4395 (8) (a) The division shall, in consultation with the Outdoor Recreation Office, establish  
4396 the fee schedule of the Search and Rescue Assistance Card under Subsection 63J-1-504(6).

4397 (b) The division shall provide a discount of not less than 10% of the card fee under  
4398 Subsection (8)(a) to a person who has paid a fee under Section 23-19-42, 41-22-34, or  
4399 73-18-24 during the same calendar year in which the person applies to be a participant in the  
4400 assistance card program.

4401 (9) (a) Counties may bill reimbursable expenses to an individual for costs incurred for  
4402 the rescue of an individual, if the individual is not a participant in the Utah Search and Rescue  
4403 Assistance Card Program.

4404 (b) Counties may bill a participant for reimbursable expenses for costs incurred for the  
4405 rescue of the participant if the participant is found by the rescuing county to have acted  
4406 recklessly or to have intentionally created a situation resulting in the need for a county to  
4407 provide rescue service for the participant.

4408 (10) (a) There is created the Utah Search and Rescue Assistance Card Program. The  
4409 program is located within the division.

4410 (b) The program may not be utilized to cover any expenses, such as medically related  
4411 expenses, that are not reimbursable expenses related to the rescue.

4412 (11) (a) To participate in the program, a person shall purchase a Search and Rescue  
4413 Assistance Card from the division by paying the fee as determined by the division in  
4414 Subsection (8).

4415 (b) The money generated by the fees shall be deposited into the General Fund as a  
4416 dedicated credit for the Search and Rescue Financial Assistance Program created in this  
4417 section.

4418 (c) Participation and payment of fees by a person under Sections 23-19-42, 41-22-34,  
4419 and 73-18-24 do not constitute purchase of a card under this section.

4420 (12) The division shall consult with the Outdoor Recreation Office regarding:

4421 (a) administration of the assistance card program; and

4422 (b) outreach and marketing strategies.

4423 (13) Pursuant to Subsection 31A-1-103(7), the Utah Search and Rescue Assistance  
4424 Card Program under this section is exempt from being considered [an] insurance [program  
4425 under Subsection] as defined in Section 31A-1-301[(86)].

4426 Section 65. Section 59-7-102 is amended to read:

4427 **59-7-102. Exemptions.**

4428 (1) Except as provided in this section, the following are exempt from a tax under this  
4429 chapter:

4430 (a) an organization exempt under Section 501, Internal Revenue Code;

4431 (b) an organization exempt under Section 528, Internal Revenue Code;

4432 (c) an insurance company that is subject to taxation on the insurance company's  
4433 premiums under Chapter 9, Taxation of Admitted Insurers, regardless of whether the insurance  
4434 company has a tax liability under that chapter;

4435 (d) a local building authority as defined in Section [17D-2-102](#);

4436 (e) a farmers' cooperative; [or]

4437 (f) a public agency, as defined in Section [11-13-103](#), with respect to or as a result of an  
4438 ownership interest in:

4439 (i) a project, as defined in Section [11-13-103](#); or

4440 (ii) facilities providing additional project capacity, as defined in Section [11-13-103](#)[-];

4441 (g) an insurance company that engages in a transaction that is subject to taxation under  
4442 Section [31A-3-301](#) or [31A-3-302](#), regardless of whether the insurance company has a tax  
4443 liability under that section; or

4444 (h) a captive insurance company that pays a fee under Section [31A-3-304](#).

4445 (2) A corporation is exempt from a tax under this chapter:

4446 (a) if the corporation is an out-of-state business as defined in Section [53-2a-1202](#); and

4447 (b) for income earned:

4448 (i) during a disaster period as defined in Section [53-2a-1202](#); and

4449 (ii) for the purpose of responding to a declared state disaster or emergency as defined  
4450 in Section [53-2a-1202](#).

4451 (3) Notwithstanding any other provision in this chapter or Chapter 8, Gross Receipts  
4452 Tax on Certain Corporations Not Required to Pay Corporate Franchise or Income Tax Act, a  
4453 person not otherwise subject to the tax imposed by this chapter or Chapter 8, Gross Receipts  
4454 Tax on Certain Corporations Not Required to Pay Corporate Franchise or Income Tax Act, is  
4455 not subject to a tax imposed by Section [59-7-104](#), [59-7-201](#), [59-7-701](#), or [59-8-104](#), because of:

4456 (a) that person's ownership of tangible personal property located at the premises of a  
4457 printer's facility in this state with which the person has contracted for printing; or

4458 (b) the activities of the person's employees or agents who are:



4459 (i) located solely at the premises of a printer's facility; and  
4460 (ii) performing services:  
4461 (A) related to:  
4462 (I) quality control;  
4463 (II) distribution; or  
4464 (III) printing services; and  
4465 (B) performed by the printer's facility in this state with which the person has contracted  
4466 for printing.

4467 (4) Notwithstanding Subsection (1), an organization, company, authority, farmers'  
4468 cooperative, or public agency exempt from this chapter under Subsection (1) is subject to Part  
4469 8, Unrelated Business Income, to the extent provided in Part 8, Unrelated Business Income.

4470 (5) Notwithstanding Subsection (1)(b), to the extent the income of an organization  
4471 described in Subsection (1)(b) is taxable for federal tax purposes under Section 528, Internal  
4472 Revenue Code, the organization's income is also taxable under this chapter.

4473 Section 66. Section **59-9-101** is amended to read:

4474 **59-9-101. Tax basis -- Rates -- Exemptions -- Rate reductions.**

4475 (1) (a) Except as provided in Subsection (1)(b), (1)(d), or (5), an admitted insurer shall  
4476 pay to the commission on or before March 31 in each year, a tax of 2-1/4% of the total  
4477 premiums received by it during the preceding calendar year from insurance covering property  
4478 or risks located in this state.

4479 (b) This Subsection (1) does not apply to:

4480 (i) workers' compensation insurance, assessed under Subsection (2);

4481 (ii) title insurance premiums taxed under Subsection (3);

4482 (iii) annuity considerations;

4483 (iv) insurance premiums paid by an institution within the state system of higher  
4484 education as specified in Section [53B-1-102](#); and

4485 (v) ocean marine insurance.

4486 (c) The taxable premium under this Subsection (1) shall be reduced by:

4487 (i) the premiums returned or credited to policyholders on direct business subject to tax  
4488 in this state;

4489 (ii) the premiums received for reinsurance of property or risks located in this state; and

4490 (iii) the dividends, including premium reduction benefits maturing within the year:  
4491 (A) paid or credited to policyholders in this state; or  
4492 (B) applied in abatement or reduction of premiums due during the preceding calendar  
4493 year.

4494 (d) (i) For purposes of this Subsection (1)(d):  
4495 (A) "Utah variable life insurance premium" means an insurance premium paid:

4496 (I) by:

4497 (Aa) a corporation; or

4498 (Bb) a trust established or funded by a corporation; and

4499 (II) for variable life insurance covering risks located within the state.

4500 (B) "Variable life insurance" means an insurance policy that provides for life  
4501 insurance, the amount or duration of which varies according to the investment experience of  
4502 one or more separate accounts that are established and maintained by the insurer pursuant to  
4503 Title 31A, Insurance Code.

4504 (ii) Notwithstanding Subsection (1)(a), beginning on January 1, 2006, the tax on that  
4505 portion of the total premiums subject to a tax under Subsection (1)(a) that is a Utah variable  
4506 life insurance premium shall be calculated as follows:

4507 (A) 2-1/4% of the first \$100,000 of Utah variable life insurance premiums:

4508 (I) paid for each variable life insurance policy; and

4509 (II) received by the admitted insurer in the preceding calendar year; and

4510 (B) 0.08% of the Utah variable life insurance premiums that exceed \$100,000:

4511 (I) paid for the policy described in Subsection (1)(d)(ii)(A); and

4512 (II) received by the admitted insurer in the preceding calendar year.

4513 (2) (a) An admitted insurer writing workers' compensation insurance in this state,  
4514 including the Workers' Compensation Fund created under Title 31A, Chapter 33, Workers'  
4515 Compensation Fund, shall pay to the tax commission, on or before March 31 in each year, a  
4516 premium assessment on the basis of the total workers' compensation premium income received  
4517 by the insurer from workers' compensation insurance in this state during the preceding calendar  
4518 year as follows:

4519 (i) on or before December 31, 2010, an amount of equal to or greater than 1%, but  
4520 equal to or less than 5.75% of the total workers' compensation premium income described in

4521 this Subsection (2);

4522 (ii) on and after January 1, 2011, but on or before December 31, 2017, an amount of  
4523 equal to or greater than 1%, but equal to or less than 4.25% of the total workers' compensation  
4524 premium income described in this Subsection (2); and

4525 (iii) on and after January 1, 2018, an amount equal to 1.25% of the total workers'  
4526 compensation premium income described in this Subsection (2).

4527 (b) Total workers' compensation premium income means the net written premium as  
4528 calculated before any premium reduction for any insured employer's deductible, retention, or  
4529 reimbursement amounts and also those amounts equivalent to premiums as provided in Section  
4530 [34A-2-202](#).

4531 (c) The percentage of premium assessment applicable for a calendar year shall be  
4532 determined by the Labor Commission under Subsection (2)(d). The total premium income  
4533 shall be reduced in the same manner as provided in Subsections (1)(c)(i) and (1)(c)(ii), but not  
4534 as provided in Subsection (1)(c)(iii). The commission shall promptly remit from the premium  
4535 assessment collected under this Subsection (2):

4536 (i) income to the state treasurer for credit to the Employers' Reinsurance Fund created  
4537 under Subsection [34A-2-702](#)(1) as follows:

4538 (A) on or before December 31, 2009, an amount of up to 5% of the total workers'  
4539 compensation premium income;

4540 (B) on and after January 1, 2010, but on or before December 31, 2010, an amount of up  
4541 to 4.5% of the total workers' compensation premium income;

4542 (C) on and after January 1, 2011, but on or before December 31, 2017, an amount of up  
4543 to 3% of the total workers' compensation premium income; and

4544 (D) on and after January 1, 2018, 0% of the total workers' compensation premium  
4545 income;

4546 (ii) an amount equal to 0.25% of the total workers' compensation premium income to  
4547 the state treasurer for credit to the Workplace Safety Account created by Section [34A-2-701](#);

4548 (iii) an amount of up to 0.5% and any remaining assessed percentage of the total  
4549 workers' compensation premium income to the state treasurer for credit to the Uninsured  
4550 Employers' Fund created under Section [34A-2-704](#); and

4551 (iv) beginning on January 1, 2010, 0.5% of the total workers' compensation premium

4552 income to the state treasurer for credit to the Industrial Accident Restricted Account created in  
4553 Section 34A-2-705.

4554 (d) (i) The Labor Commission shall determine the amount of the premium assessment  
4555 for each year on or before each October 15 of the preceding year. The Labor Commission shall  
4556 make this determination following a public hearing. The determination shall be based upon the  
4557 recommendations of a qualified actuary.

4558 (ii) The actuary shall recommend a premium assessment rate sufficient to provide  
4559 payments of benefits and expenses from the Employers' Reinsurance Fund and to project a  
4560 funded condition with assets greater than liabilities by no later than June 30, 2025.

4561 (iii) The actuary shall recommend a premium assessment rate sufficient to provide  
4562 payments of benefits and expenses from the Uninsured Employers' Fund and to maintain it at a  
4563 funded condition with assets equal to or greater than liabilities.

4564 (iv) At the end of each fiscal year the minimum approximate assets in the Employers'  
4565 Reinsurance Fund shall be \$5,000,000 which amount shall be adjusted each year beginning in  
4566 1990 by multiplying by the ratio that the total workers' compensation premium income for the  
4567 preceding calendar year bears to the total workers' compensation premium income for the  
4568 calendar year 1988.

4569 (v) The requirements of Subsection (2)(d)(iv) cease when the future annual  
4570 disbursements from the Employers' Reinsurance Fund are projected to be less than the  
4571 calculations of the corresponding future minimum required assets. The Labor Commission  
4572 shall, after a public hearing, determine if the future annual disbursements are less than the  
4573 corresponding future minimum required assets from projections provided by the actuary.

4574 (vi) At the end of each fiscal year the minimum approximate assets in the Uninsured  
4575 Employers' Fund shall be \$2,000,000, which amount shall be adjusted each year beginning in  
4576 1990 by multiplying by the ratio that the total workers' compensation premium income for the  
4577 preceding calendar year bears to the total workers' compensation premium income for the  
4578 calendar year 1988.

4579 (e) A premium assessment that is to be transferred into the General Fund may be  
4580 collected on premiums received from Utah public agencies.

4581 (3) An admitted insurer writing title insurance in this state shall pay to the commission,  
4582 on or before March 31 in each year, a tax of .45% of the total premium received by either the

4583 insurer or by its agents during the preceding calendar year from title insurance concerning  
4584 property located in this state. In calculating this tax, "premium" includes the charges made to  
4585 an insured under or to an applicant for a policy or contract of title insurance for:

4586 (a) the assumption by the title insurer of the risks assumed by the issuance of the policy  
4587 or contract of title insurance; and

4588 (b) abstracting title, title searching, examining title, or determining the insurability of  
4589 title, and every other activity, exclusive of escrow, settlement, or closing charges, whether  
4590 denominated premium or otherwise, made by a title insurer, an agent of a title insurer, a title  
4591 insurance producer, or any of them.

4592 (4) Beginning July 1, 1986, a former county mutual and a former mutual benefit  
4593 association shall pay the premium tax or assessment due under this chapter. Premiums  
4594 received after July 1, 1986, shall be considered in determining the tax or assessment.

4595 (5) The following insurers are not subject to the premium tax on health care insurance  
4596 that would otherwise be applicable under Subsection (1):

4597 (a) an insurer licensed under Title 31A, Chapter 5, Domestic Stock and Mutual  
4598 Insurance Corporations;

4599 (b) an insurer licensed under Title 31A, Chapter 7, Nonprofit Health Service Insurance  
4600 Corporations;

4601 (c) an insurer licensed under Title 31A, Chapter 8, Health Maintenance Organizations  
4602 and Limited Health Plans;

4603 (d) an insurer licensed under Title 31A, Chapter 9, Insurance Fraternal;

4604 (e) an insurer licensed under Title 31A, Chapter 11, Motor Clubs;

4605 (f) an insurer licensed under Title 31A, Chapter 13, Employee Welfare Funds and  
4606 Plans; and

4607 (g) an insurer licensed under Title 31A, Chapter 14, Foreign Insurers.

4608 (6) A captive insurer, as provided in Section 31A-3-304, that pays a fee imposed under  
4609 Section 31A-3-304 is not subject to the premium tax under this section.

4610 ~~[(6)]~~ (7) An insurer issuing multiple policies to an insured may not artificially allocate  
4611 the premiums among the policies for purposes of reducing the aggregate premium tax or  
4612 assessment applicable to the policies.

4613 ~~[(7)]~~ (8) The retaliatory provisions of Title 31A, Chapter 3, Department Funding, Fees,

4614 and Taxes, apply to the tax or assessment imposed under this chapter.

4615 Section 67. Section **63G-2-302** is amended to read:

4616 **63G-2-302. Private records.**

4617 (1) The following records are private:

4618 (a) records concerning an individual's eligibility for unemployment insurance benefits,  
4619 social services, welfare benefits, or the determination of benefit levels;

4620 (b) records containing data on individuals describing medical history, diagnosis,  
4621 condition, treatment, evaluation, or similar medical data;

4622 (c) records of publicly funded libraries that when examined alone or with other records  
4623 identify a patron;

4624 (d) records received by or generated by or for:

4625 (i) the Independent Legislative Ethics Commission, except for:

4626 (A) the commission's summary data report that is required under legislative rule; and

4627 (B) any other document that is classified as public under legislative rule; or

4628 (ii) a Senate or House Ethics Committee in relation to the review of ethics complaints,  
4629 unless the record is classified as public under legislative rule;

4630 (e) records received by, or generated by or for, the Independent Executive Branch  
4631 Ethics Commission, except as otherwise expressly provided in Title 63A, Chapter 14, Review  
4632 of Executive Branch Ethics Complaints;

4633 (f) records received or generated for a Senate confirmation committee concerning  
4634 character, professional competence, or physical or mental health of an individual:

4635 (i) if, prior to the meeting, the chair of the committee determines release of the records:

4636 (A) reasonably could be expected to interfere with the investigation undertaken by the  
4637 committee; or

4638 (B) would create a danger of depriving a person of a right to a fair proceeding or  
4639 impartial hearing; and

4640 (ii) after the meeting, if the meeting was closed to the public;

4641 (g) employment records concerning a current or former employee of, or applicant for  
4642 employment with, a governmental entity that would disclose that individual's home address,  
4643 home telephone number, social security number, insurance coverage, marital status, or payroll  
4644 deductions;

- 4645 (h) records or parts of records under Section 63G-2-303 that a current or former  
4646 employee identifies as private according to the requirements of that section;
- 4647 (i) that part of a record indicating a person's social security number or federal employer  
4648 identification number if provided under Section 31A-23a-104, 31A-25-202, 31A-26-202,  
4649 58-1-301, 58-55-302, 61-1-4, or 61-2f-203;
- 4650 (j) that part of a voter registration record identifying a voter's:
- 4651 (i) driver license or identification card number;
- 4652 (ii) Social Security number, or last four digits of the Social Security number;
- 4653 (iii) email address; or
- 4654 (iv) date of birth;
- 4655 (k) a voter registration record that is classified as a private record by the lieutenant  
4656 governor or a county clerk under Subsection 20A-2-104(4)(f) or 20A-2-101.1(5)(a);
- 4657 (l) a record that:
- 4658 (i) contains information about an individual;
- 4659 (ii) is voluntarily provided by the individual; and
- 4660 (iii) goes into an electronic database that:
- 4661 (A) is designated by and administered under the authority of the Chief Information  
4662 Officer; and
- 4663 (B) acts as a repository of information about the individual that can be electronically  
4664 retrieved and used to facilitate the individual's online interaction with a state agency;
- 4665 (m) information provided to the Commissioner of Insurance under:
- 4666 (i) Subsection 31A-23a-115[(2)](3)(a);
- 4667 (ii) Subsection 31A-23a-302[(3)](4); or
- 4668 (iii) Subsection 31A-26-210[(3)](4);
- 4669 (n) information obtained through a criminal background check under Title 11, Chapter  
4670 40, Criminal Background Checks by Political Subdivisions Operating Water Systems;
- 4671 (o) information provided by an offender that is:
- 4672 (i) required by the registration requirements of Title 77, Chapter 41, Sex and Kidnap  
4673 Offender Registry; and
- 4674 (ii) not required to be made available to the public under Subsection 77-41-110(4);
- 4675 (p) a statement and any supporting documentation filed with the attorney general in

4676 accordance with Section 34-45-107, if the federal law or action supporting the filing involves  
4677 homeland security;

4678 (q) electronic toll collection customer account information received or collected under  
4679 Section 72-6-118 and customer information described in Section 17B-2a-815 received or  
4680 collected by a public transit district, including contact and payment information and customer  
4681 travel data;

4682 (r) an email address provided by a military or overseas voter under Section  
4683 20A-16-501;

4684 (s) a completed military-overseas ballot that is electronically transmitted under Title  
4685 20A, Chapter 16, Uniform Military and Overseas Voters Act;

4686 (t) records received by or generated by or for the Political Subdivisions Ethics Review  
4687 Commission established in Section 11-49-201, except for:

4688 (i) the commission's summary data report that is required in Section 11-49-202; and

4689 (ii) any other document that is classified as public in accordance with Title 11, Chapter  
4690 49, Political Subdivisions Ethics Review Commission;

4691 (u) a record described in Subsection 53A-11a-203(3) that verifies that a parent was  
4692 notified of an incident or threat; and

4693 (v) a criminal background check or credit history report conducted in accordance with  
4694 Section 63A-3-201.

4695 (2) The following records are private if properly classified by a governmental entity:

4696 (a) records concerning a current or former employee of, or applicant for employment  
4697 with a governmental entity, including performance evaluations and personal status information  
4698 such as race, religion, or disabilities, but not including records that are public under Subsection  
4699 63G-2-301(2)(b) or 63G-2-301(3)(o) or private under Subsection (1)(b);

4700 (b) records describing an individual's finances, except that the following are public:

4701 (i) records described in Subsection 63G-2-301(2);

4702 (ii) information provided to the governmental entity for the purpose of complying with  
4703 a financial assurance requirement; or

4704 (iii) records that must be disclosed in accordance with another statute;

4705 (c) records of independent state agencies if the disclosure of those records would  
4706 conflict with the fiduciary obligations of the agency;



4707 (d) other records containing data on individuals the disclosure of which constitutes a  
4708 clearly unwarranted invasion of personal privacy;

4709 (e) records provided by the United States or by a government entity outside the state  
4710 that are given with the requirement that the records be managed as private records, if the  
4711 providing entity states in writing that the record would not be subject to public disclosure if  
4712 retained by it;

4713 (f) any portion of a record in the custody of the Division of Aging and Adult Services,  
4714 created in Section 62A-3-102, that may disclose, or lead to the discovery of, the identity of a  
4715 person who made a report of alleged abuse, neglect, or exploitation of a vulnerable adult; and

4716 (g) audio and video recordings created by a body-worn camera, as defined in Section  
4717 77-7a-103, that record sound or images inside a home or residence except for recordings that:

4718 (i) depict the commission of an alleged crime;

4719 (ii) record any encounter between a law enforcement officer and a person that results in  
4720 death or bodily injury, or includes an instance when an officer fires a weapon;

4721 (iii) record any encounter that is the subject of a complaint or a legal proceeding  
4722 against a law enforcement officer or law enforcement agency;

4723 (iv) contain an officer involved critical incident as defined in Section 76-2-408(1)(d);

4724 or

4725 (v) have been requested for reclassification as a public record by a subject or  
4726 authorized agent of a subject featured in the recording.

4727 (3) (a) As used in this Subsection (3), "medical records" means medical reports,  
4728 records, statements, history, diagnosis, condition, treatment, and evaluation.

4729 (b) Medical records in the possession of the University of Utah Hospital, its clinics,  
4730 doctors, or affiliated entities are not private records or controlled records under Section  
4731 63G-2-304 when the records are sought:

4732 (i) in connection with any legal or administrative proceeding in which the patient's  
4733 physical, mental, or emotional condition is an element of any claim or defense; or

4734 (ii) after a patient's death, in any legal or administrative proceeding in which any party  
4735 relies upon the condition as an element of the claim or defense.

4736 (c) Medical records are subject to production in a legal or administrative proceeding  
4737 according to state or federal statutes or rules of procedure and evidence as if the medical

4738 records were in the possession of a nongovernmental medical care provider.

4739 Section 68. **Repealer.**

4740 This bill repeals:

4741 Section [31A-22-715](#), **Alcohol and drug dependency treatment.**

4742 Section [31A-22-718](#), **Dependent coverage.**

4743 Section [31A-37-306](#), **Conversion or merger.**

4744 Section 69. **Retrospective operation.**

4745 (1) The amendments in this bill to Section [31A-3-102](#) and Section [59-7-102](#) have  
4746 retrospective operation for a taxable year beginning on or after January 1, 2017, except that the  
4747 amendments to Subsections [31A-3-102](#)(2)(b) and [59-7-102](#)(1)(g) have retrospective operation  
4748 for a taxable year beginning on or after January 1, 2011.

4749 (2) The amendments in this bill to Section [59-9-101](#) have retrospective operation to  
4750 January 1, 2017.