INSURANCE AMENDMENTS

2024 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Curtis S. Bramble

House Sponsor: James A. Dunnigan

LONG TITLE

General Description:

This bill updates the Insurance Code.

Highlighted Provisions:

This bill:

- defines terms;
- exempts a health care sharing ministry from regulation under the Insurance Code, provided the health care sharing ministry makes certain disclosures to participants;
- requires that the commissioner evaluate annually the state's health insurance market and provide that evaluation to the Health and Human Services Interim Committee;
- removes provisions relating to the commissioner declaring a rule in effect during a transition period;
- clarifies the scope of the consumer assistance that the commissioner provides;
- authorizes an insurer to electronically deliver a policy document to an insured under certain conditions;
- expands the list of prohibited life insurance policy provisions;
- updates the duties of the Office of Consumer Health Assistance;
- modifies the commissioner's enforcement authority to allow the commissioner to accept or compromise a forfeiture after the filing of a complaint;
- amends provisions relating to mutual insurance holding companies;
- amends the enforcement provisions under this chapter;
- removes the filing fee for a rate filing;
- addresses the allowable amount of a rate or other charge used by a title insurer;
- allows a licensee to make installment payments on a judgment if the payments are not more than 60 days overdue;

‣ requires that certain licensees and prospective licensees report to the commissioner any civil action that is filed against the licensee or prospective licensee and involves conduct related to a professional or occupational license;

‣ institutes new capital and net worth requirements for title insurance producers;

‣ removes the requirement that an individual title insurance producer file an annual report with the commissioner;

‣ allows a federal home loan bank to obtain collateral pledged by an insurer-member when the member-insurer is in receivership;

‣ requires that the commissioner conduct a study and produce a report relating to lowering health benefit plan insurance premiums and market stabilization;

‣ increases the fee that the commissioner may assess certain admitted and nonadmitted insurers;

‣ authorizes an association captive insurance company to provide homeowners' insurance, subject to commissioner approval; and

‣ makes technical changes.

Money Appropriated in this Bill:

This bill appropriates in fiscal year 2025:

‣ to Insurance Department - Insurance Department Administration as a one-time appropriation:

• from the General Fund Restricted - Relative Value Study Account, One-time, $400,000

Other Special Clauses:

This bill provides a special effective date.

Utah Code Sections Affected:

AMENDS:

31A-1-103 (Effective 05/01/24), as last amended by Laws of Utah 2021, Chapter 252

31A-1-301 (Effective 05/01/24), as last amended by Laws of Utah 2023, Chapter 327

31A-2-201.2 (Effective 05/01/24), as last amended by Laws of Utah 2019, Chapters 241, 439

31A-2-211 (Effective 05/01/24), as last amended by Laws of Utah 1987, Chapter 161

31A-2-215 (Effective 05/01/24), as last amended by Laws of Utah 2002, Chapter 308

31A-2-216 (Effective 05/01/24), as last amended by Laws of Utah 2002, Chapter 308

31A-2-308 (Effective 05/01/24), as last amended by Laws of Utah 2019, Chapter 193

31A-4-113.5 (Effective 05/01/24), as last amended by Laws of Utah 2023, Chapter 194

31A-6a-109 (Effective 05/01/24), as enacted by Laws of Utah 1992, Chapter 203

31A-16-102.6 (Effective 05/01/24), as enacted by Laws of Utah 2022, Chapter 198
31A-19a-203 (Effective 05/01/24), as last amended by Laws of Utah 2004, Chapter 117
31A-19a-209 (Effective 05/01/24), as last amended by Laws of Utah 2023, Chapter 194
31A-20-108 (Effective 05/01/24), as last amended by Laws of Utah 2009, Chapter 349
31A-21-316 (Effective 05/01/24), as enacted by Laws of Utah 2014, Chapter 77
31A-21-402 (Effective 05/01/24), as last amended by Laws of Utah 2021, Chapter 252
31A-22-401 (Effective 05/01/24), as last amended by Laws of Utah 1986, Chapter 204
31A-22-605 (Effective 05/01/24), as last amended by Laws of Utah 2017, Chapter 168
31A-22-614 (Effective 07/01/24), as last amended by Laws of Utah 2011, Chapter 366
31A-22-620 (Effective 05/01/24), as last amended by Laws of Utah 2015, Chapter 244
31A-22-802 (Effective 05/01/24), as last amended by Laws of Utah 2011, Chapter 366
31A-22-2002 (Effective 05/01/24), as last amended by Laws of Utah 2021, Chapter 252
31A-23a-105 (Effective 05/01/24), as last amended by Laws of Utah 2014, Chapters 290, 300
31A-23a-111 (Effective 05/01/24), as last amended by Laws of Utah 2023, Chapter 194
31A-23a-406 (Effective 05/01/24), as last amended by Laws of Utah 2023, Chapter 194
31A-23a-413 (Effective 05/01/24), as last amended by Laws of Utah 2015, Chapter 312
31A-26-301.6 (Effective 05/01/24), as last amended by Laws of Utah 2023, Chapter 328
31A-28-113 (Effective 05/01/24), as last amended by Laws of Utah 2018, Chapter 391
31A-31-108 (Effective 05/01/24), as last amended by Laws of Utah 2013, Chapter 319
31A-35-202 (Effective 05/01/24), as last amended by Laws of Utah 2016, Chapter 234
31A-35-406 (Effective 05/01/24), as last amended by Laws of Utah 2021, Chapter 252
31A-37-202 (Effective 05/01/24), as last amended by Laws of Utah 2023, Chapter 194
31A-37-204 (Effective 05/01/24), as last amended by Laws of Utah 2023, Chapter 194
31A-37-502 (Effective 05/01/24), as last amended by Laws of Utah 2019, Chapter 193

ENACTS:

31A-2-218.1 (Effective upon governor's approval), Utah Code Annotated 1953
31A-23a-119 (Effective 05/01/24), Utah Code Annotated 1953
31A-27a-108.1 (Effective 05/01/24), Utah Code Annotated 1953

REPEALS:

31A-2-303 (Effective 05/01/24), as last amended by Laws of Utah 2009, Chapter 388

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

Section 1. Section **31A-1-103** is amended to read:

31A-1-103 (Effective 05/01/24). Scope and applicability of title.

(1) This title does not apply to:

(a) a retainer contract made by an attorney-at-law:

(i) with an individual client; and

(ii) under which fees are based on estimates of the nature and amount of services to be provided to the specific client;

(b) a contract similar to a contract described in Subsection (1)(a) made with a group of clients involved in the same or closely related legal matters;

(c) an arrangement for providing benefits that do not exceed a limited amount of consultations, advice on simple legal matters, either alone or in combination with referral services, or the promise of fee discounts for handling other legal matters;

(d) limited legal assistance on an informal basis involving neither an express contractual obligation nor reasonable expectations, in the context of an employment, membership, educational, or similar relationship;

(e) legal assistance by employee organizations to their members in matters relating to employment;

(f) death, accident, health, or disability benefits provided to a person by an organization or its affiliate if:

(i) the organization is tax exempt under Section 501(c)(3) of the Internal Revenue Code and has had its principal place of business in Utah for at least five years;

(ii) the person is not an employee of the organization; and

(iii) (A) substantially all the person's time in the organization is spent providing voluntary services:

(I) in furtherance of the organization's purposes;

(II) for a designated period of time; and

(III) for which no compensation, other than expenses, is paid; or

(B) the time since the service under Subsection (1)(f)(iii)(A) was completed is no more than 18 months; or

(g) a prepaid contract of limited duration that provides for scheduled maintenance only.

(2) (a) This title restricts otherwise legitimate business activity.

(b) What this title does not prohibit is permitted unless contrary to other provisions of Utah law.

(3) Except as otherwise expressly provided, this title does not apply to:

(a) those activities of an insurer where state jurisdiction is preempted by Section 514 of

the federal Employee Retirement Income Security Act of 1974, as amended;

(b) ocean marine insurance;

(c) death, accident, health, or disability benefits provided by an organization [~~if the organization:~~] that:

(i) has as the organization's principal purpose to achieve charitable, educational, social, or religious objectives rather than to provide death, accident, health, or disability benefits;

(ii) does not incur a legal obligation to pay a specified amount;[~~ and~~]

(iii) does not create reasonable expectations of receiving a specified amount on the part of an insured person; and

(iv) is not a health care sharing ministry that provides that a participant make a contribution to pay another participant's qualified expenses with no assumption of risk or promise to pay.

(d) other business specified in rules adopted by the commissioner on a finding that:

(i) the transaction of the business in this state does not require regulation for the protection of the interests of the residents of this state; or

(ii) it would be impracticable to require compliance with this title;

(e) except as provided in Subsection (4), a transaction independently procured through negotiations under Section 31A-15-104;

(f) self-insurance;

(g) reinsurance;

(h) subject to Subsection (5), an employee or labor union group insurance policy covering risks in this state or an employee or labor union blanket insurance policy covering risks in this state, if:

(i) the policyholder exists primarily for purposes other than to procure insurance;

(ii) the policyholder:

(A) is not a resident of this state;

(B) is not a domestic corporation; or

(C) does not have the policyholder's principal office in this state;

(iii) no more than 25% of the certificate holders or insureds are residents of this state;

(iv) on request of the commissioner, the insurer files with the department a copy of the policy and a copy of each form or certificate; and

(v) (A) the insurer agrees to pay premium taxes on the Utah portion of the insurer's business, as if the insurer were authorized to do business in this state;

and

(B) the insurer provides the commissioner with the security the commissioner considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of Admitted Insurers;

(i) to the extent provided in Subsection (6):

(i) a manufacturer's or seller's warranty; and

(ii) a manufacturer's or seller's service contract;

(j) except to the extent provided in Subsection (7), a public agency insurance mutual;[~~or~~]

(k) except as provided in Chapter 6b, Guaranteed Asset Protection Waiver Act, a guaranteed asset protection waiver[~~.~~] ; or

(l) a health care sharing ministry, if the health care sharing ministry:

(i) provides to each participant upon enrollment and annually thereafter a written statement of nationwide data from the preceding calendar year that lists the total dollar amount of contributions provided to participants toward qualified expenses; and

(ii) includes a written disclaimer, titled "Notice", on or with each application and all guideline materials that states:

(A) the health care sharing ministry is not an insurance company;

(B) nothing the health care sharing ministry offers or provides is an insurance policy, including the health care sharing ministry's guidelines or plan of operations;

(C) participation in the health care sharing ministry is entirely voluntary and no participant is compelled by law to contribute to another participant's expenses;

(D) participation in the health care sharing ministry or subscription to any of the health care sharing ministry's services is not insurance; and

(E) each participant is always personally responsible for the participant's expenses regardless of whether the participant receives payment for the expenses through the health care sharing ministry or whether this health care sharing ministry continues to operate.

(4) A transaction described in Subsection (3)(e) is subject to taxation under Section 31A-3-301.

(5) (a) After a hearing, the commissioner may order an insurer of certain group insurance policies or blanket insurance policies to transfer the Utah portion of the

business otherwise exempted under Subsection (3)(h) to an authorized insurer if the contracts have been written by an unauthorized insurer.

(b) If the commissioner finds that the conditions required for the exemption of a group or blanket insurer are not satisfied or that adequate protection to residents of this state is not provided, the commissioner may require:

(i) the insurer to be authorized to do business in this state; or

(ii) that any of the insurer's transactions be subject to this title.

(c) Subsection (3)(h) does not apply to a blanket insurance policy offering accident and health insurance.

(6) (a) As used in Subsection (3)(i) and this Subsection (6):

(i) "manufacturer's or seller's service contract" means a service contract:

(A) made available by:

(I) a manufacturer of a product;

(II) a seller of a product; or

(III) an affiliate of a manufacturer or seller of a product;

(B) made available:

(I) on one or more specific products; or

(II) on products that are components of a system; and

(C) under which the person described in Subsection (6)(a)(i)(A) is liable for services to be provided under the service contract including, if the manufacturer's or seller's service contract designates, providing parts and labor;

(ii) "manufacturer's or seller's warranty" means the guaranty of:

(A) (I) the manufacturer of a product;

(II) a seller of a product; or

(III) an affiliate of a manufacturer or seller of a product;

(B) (I) on one or more specific products; or

(II) on products that are components of a system; and

(C) under which the person described in Subsection (6)(a)(ii)(A) is liable for services to be provided under the warranty, including, if the manufacturer's or seller's warranty designates, providing parts and labor; and

(iii) "service contract" means the same as that term is defined in Section 31A-6a-101.

(b) A manufacturer's or seller's warranty may be designated as:

(i) a warranty;

(ii) a guaranty; or

(iii) a term similar to a term described in Subsection (6)(b)(i) or (ii).

(c) This title does not apply to:

(i) a manufacturer's or seller's warranty;

(ii) a manufacturer's or seller's service contract paid for with consideration that is in addition to the consideration paid for the product itself; and

(iii) a service contract that is not a manufacturer's or seller's warranty or manufacturer's or seller's service contract if:

(A) the service contract is paid for with consideration that is in addition to the consideration paid for the product itself;

(B) the service contract is for the repair or maintenance of goods;

(C) the purchase price of the product is $3,700 or less;

(D) the product is not a motor vehicle; and

(E) the product is not the subject of a home warranty service contract.

(d) This title does not apply to a manufacturer's or seller's warranty or service contract paid for with consideration that is in addition to the consideration paid for the product itself regardless of whether the manufacturer's or seller's warranty or service contract is sold:

(i) at the time of the purchase of the product; or

(ii) at a time other than the time of the purchase of the product.

(7) (a) For purposes of this Subsection (7), "public agency insurance mutual" means an entity formed by two or more political subdivisions or public agencies of the state:

(i) under Title 11, Chapter 13, Interlocal Cooperation Act; and

(ii) for the purpose of providing for the political subdivisions or public agencies:

(A) subject to Subsection (7)(b), insurance coverage; or

(B) risk management.

(b) Notwithstanding Subsection (7)(a)(ii)(A), a public agency insurance mutual may not provide health insurance unless the public agency insurance mutual provides the health insurance using:

(i) a third party administrator licensed under Chapter 25, Third Party Administrators;

(ii) an admitted insurer; or

(iii) a program authorized by Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

(c) Except for this Subsection (7), a public agency insurance mutual is exempt from this title.

(d) A public agency insurance mutual is considered to be a governmental entity and political subdivision of the state with all of the rights, privileges, and immunities of a governmental entity or political subdivision of the state including all the rights and benefits of Title 63G, Chapter 7, Governmental Immunity Act of Utah.

Section 2. Section **31A-1-301** is amended to read:

31A-1-301 (Effective 05/01/24). Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) a fixed indemnity contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

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

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title

63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) "Administrator" means the same as that term is defined in Subsection [~~(182).~~] (187).

(4) "Adult" means an individual who is 18 years old or older.

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

(6) "Agency" means:

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

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

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

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

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

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

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

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

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

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

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

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

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

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

(a) without individual underwriting or application; and

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

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

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

(a) that is open to the public;

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

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

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(18) "Business of insurance" means the same as that term is defined in Subsection [~~(95).~~] (98).

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

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

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

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

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

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by a parent organization; and

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

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

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

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

(i) owned by the insureds; and

(ii) whose purpose is to insure risks of:

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

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

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

(b) a third party.

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

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

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

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

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

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

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

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

(A) for the life of the insured; or

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

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

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

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

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

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

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

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

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

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

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

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

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

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

(i) the Primary Care Network Program under a Medicaid primary care network demonstration waiver obtained subject to Section 26B-3-108;

(ii) the Children's Health Insurance Program under Section 26B-3-904; or

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

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

(37) (a) "Credit insurance" means insurance offered in connection with an extension of

credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

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

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(40) "Credit property insurance" means insurance:

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

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

(41) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

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

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

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

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

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

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

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

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

(47) "Department" means the Insurance Department.

(48) (a) "Direct response solicitation" means an offer for life or accident and health insurance coverage that allows the individual to apply for or enroll in the insurance coverage on the basis of the offer.

(b) "Direct response solicitation" does not include an offer for:

(i) insurance through an employee benefit plan that is exempt from state regulation under federal law; or

(ii) credit life insurance or credit accident and health insurance through a individual's creditor.

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

[~~(48)~~] (50) "Director" means a member of the board of directors of a corporation.

[~~(49)~~] (51) "Disability" means a physiological or psychological condition that partially or totally limits an individual's ability to:

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

[~~(50)~~] (52) "Disability income insurance" means the same as that term is defined in Subsection [~~(86).~~] (89).

[~~(51)~~] (53) "Domestic insurer" means an insurer organized under the laws of this state.

[~~(52)~~] (54) "Domiciliary state" means the state in which an insurer:

(a) is incorporated;

(b) is organized; or

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

[~~(53)~~] (55) (a) "Eligible employee" means:

(i) an employee who:

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

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

(ii) a person described in Subsection [~~(53)(b).~~] (55)(b).

(b) "Eligible employee" includes:

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

(A) works on a full-time basis;

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

(C) employs at least one common employee; and

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

(c) "Eligible employee" does not include, unless eligible under Subsection [~~(53)(b).~~] (55)(b):

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

(ii) an employer's spouse who does not meet the requirements of Subsection [~~(53)(a)(i);~~] (55)(a)(i); or

(iii) a dependent of an employer who does not meet the requirements of Subsection [~~(53)(a)(i).~~] (55)(a)(i).

[~~(54)~~] (56) "Emergency medical condition" means a medical condition that:

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

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

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

(ii) serious impairment to bodily functions; or

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

[~~(55)~~] (57) "Employee" means:

(a) an individual employed by an employer; or

(b) an individual who meets the requirements of Subsection [~~(53)(b).~~] (55)(b).

[~~(56)~~] (58) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

[~~(57)~~] (59) (a) "Employee welfare fund" means a fund:

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

(A) one or more employers;

(B) one or more labor organizations; or

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

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

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

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

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

[~~(58)~~] (60) "Endorsement" means a written agreement attached to a policy or certificate to modify the policy or certificate coverage.

[~~(59)~~] (61) (a) "Enrollee" means:

(i) a policyholder;

(ii) a certificate holder;

(iii) a subscriber; or

(iv) a covered individual:

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

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

(b) "Enrollee" includes an insured.

[~~(60)~~] (62) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or

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

[~~(61)~~] (63) "Enterprise risk" means an activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything that would cause:

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

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

[~~(62)~~] (64) (a) "Escrow" means:

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

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

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

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" does not include:

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

(A) an acknowledgment;

(B) a copy certification;

(C) jurat; and

(D) an oath or affirmation;

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

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

[~~(63)~~] (65) "Escrow agent" means an agency title insurance producer meeting the requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an individual title insurance producer licensed with an escrow subline of authority.

[~~(64)~~] (66) (a) "Excludes" is not exhaustive and does not mean that another thing is not also excluded.

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

[~~(65)~~] (67) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

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

[~~(66)~~] (68) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding a position of public or private trust.

[~~(67)~~] (69) (a) "Filed" means that a filing is:

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

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

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

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

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection [~~(67)(a).~~] (69)(a).

[~~(68)~~] (70) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement;

(o) a binder; or

(p) an outline of coverage.

[~~(69)~~] (71) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay a claim submitted to it by the insured for the insured's losses.

[~~(70)~~] (72) (a) "Fixed indemnity insurance" means accident and health insurance written to provide a fixed amount for a specified event relating to or resulting from an illness or injury.

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

[~~(71)~~] (73) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(72)~~] (74) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

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

[~~(73)~~] (75) "Franchise insurance" means an individual insurance policy provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

[~~(74)~~] (76) "General lines of authority" include:

(a) the general lines of insurance in Subsection [~~(75);~~] (77);

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

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

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

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

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

[~~(75)~~] (77) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

[~~(76)~~] (78) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

[~~(77)~~] (79) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

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

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

(A) the policy; or

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

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

[~~(78)~~] (80) "Group-wide supervisor" means the commissioner or other regulatory official designated as the group-wide supervisor for an internationally active insurance group under Section 31A-16-108.6.

[~~(79)~~] (81) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

[~~(80)~~] (82) (a) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care, including major medical expense coverage.

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

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

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

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

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics;

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

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

(A) limited scope dental or vision benefits;

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

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

(x) the following benefits if the benefits are provided under a separate policy,

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

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

(B) fixed indemnity insurance;

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

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

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

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

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

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

[~~(81)~~] (83) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

[~~(82)~~] (84) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

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

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

[~~(83)~~] (85) "Health care provider" means the same as that term is defined in Section 78B-3-403.

(86) "Health care sharing ministry" means an entity that:

(a) is a tax-exempt nonprofit entity under the Internal Revenue Code;

(b) limits participants to those who are of a similar faith;

(c) facilitates the sharing of a participant's qualified expenses, as defined by the entity, among other participants by:

(i) matching a participant who has qualified expenses with one or more participants who are able to contribute to paying for the qualified expenses; and

(ii) arranging, directly or indirectly, for each contributing participant's contribution to be used to pay for the qualified expenses;

(d) requires an individual to make one or more minimum payments or contributions as a condition of one or more of the following:

(i) becoming a participant;

(ii) remaining a participant; or

(iii) receiving a contribution to pay qualified expenses; and

(e) in carrying out the functions described in this Subsection (86), makes no assumption of risk or promise to pay any qualified expenses.

[~~(84)~~] (87) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec. 155.20.

[~~(85)~~] (88) "Health Insurance Portability and Accountability Act" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.

[~~(86)~~] (89) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(87)~~] (90) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(88)~~] (91) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

[~~(89)~~] (92) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(90)~~] (93) "Individual" means a natural person.

[~~(91)~~] (94) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

[~~(92)~~] (95) "Insolvency" or "insolvent" means that:

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

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

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

[~~(93)~~] (96) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

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

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

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

[~~(94)~~] (97) "Insurance adjuster" means a person who directs or conducts the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(95)~~] (98) "Insurance business" or "business of insurance" includes:

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

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

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

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

(c) providing an annuity:

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

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

(d) providing the characteristic services of a motor club;

(e) providing another person with insurance;

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections [~~(95)(a)~~] (98)(a) through (h) in a manner designed to evade this title.

[~~(96)~~] (99) "Insurance consultant" or "consultant" means a person who:

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

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

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

[~~(97)~~] (100) "Insurance group" means the persons that comprise an insurance holding company system.

[~~(98)~~] (101) "Insurance holding company system" means a group of two or more affiliated

persons, at least one of whom is an insurer.

[~~(99)~~] (102) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

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

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

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

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

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

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

[~~(100)~~] (103) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection [~~(100)(a):~~] (103)(a):

(i) applies only to this title;

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

(iii) includes an enrollee.

[~~(101)~~] (104) (a) "Insurer," "carrier," "insurance carrier," or "insurance company" means a person doing an insurance business as a principal including:

(i) a fraternal benefit society;

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

(iii) a motor club;

(iv) an employee welfare plan;

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

(vi) a health maintenance organization.

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

[~~(102)~~] (105) "Interinsurance exchange" means the same as that term is defined in Subsection [~~(163).~~] (168).

[~~(103)~~] (106) "Internationally active insurance group" means an insurance holding company system:

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

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

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

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

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

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

[~~(104)~~] (107) "Involuntary unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

[~~(105)~~] (108) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

[~~(106)~~] (109) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

[~~(107)~~] (110) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

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

(b) through special enrollment.

[~~(108)~~] (111) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal expense.

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

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

[~~(109)~~] (112) (a) "Liability insurance" means insurance against liability:

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

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

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

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

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

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

[~~(110)~~] (113) (a) "License" means authorization issued by the commissioner to engage in an activity that is part of or related to the insurance business.

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

[~~(111)~~] (114) (a) "Life insurance" means:

(i) insurance on a human life; and

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

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

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

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

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

[~~(112)~~] (115) "Limited license" means a license that:

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

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

[~~(113)~~] (116) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

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

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

[~~(114)~~] (117) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to an individual through a master, corporate, group, or individual policy.

[~~(115)~~] (118) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

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

[~~(116)~~] (119) "Limited lines authority" includes the lines of insurance listed in Subsection [~~(115).~~] (118).

[~~(117)~~] (120) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

[~~(118)~~] (121) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(118)(a)(iv)(A)~~] (121)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage;

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

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

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement; or

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

[~~(119)~~] (122) "Managed care organization" means a person:

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

(b) (i) licensed under:

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

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

(C) Chapter 14, Foreign Insurers; and

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

[~~(120)~~] (123) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

(124) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the federal Social Security Act, as then constituted or later amended.

(125) (a) "Medicare supplement insurance" means health insurance coverage that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of individuals eligible for Medicare.

(b) "Medicare supplement insurance" does not include:

(i) a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act;

(ii) a policy issued under a demonstration project specified in 42 U.S.C. Sec. 1395ss(g)(1);

(iii) a Medicare Advantage plan established under Medicare Part C;

(iv) an outpatient prescription drug plan established under Medicare Part D; or

(v) any health care prepayment plan that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

[~~(121)~~] (126) "Member" means a person having membership rights in an insurance corporation.

[~~(122)~~] (127) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(123)~~] (128) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due

on a mortgage while the debtor has a disability.

[~~(124)~~] (129) "Mortgage guaranty insurance" means surety insurance under which a mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

[~~(125)~~] (130) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

[~~(126)~~] (131) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections [~~(126)(b)(iii)(A)~~] (131)(b)(iii)(A) through (D); or

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

[~~(127)~~] (132) "Mutual" means a mutual insurance corporation.

[~~(128)~~] (133) "NAIC" means the National Association of Insurance Commissioners.

[~~(129)~~] (134) "NAIC liquidity stress test framework" means a NAIC publication that includes:

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

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

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

[~~(130)~~] (135) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

(b) under which the financing and delivery of medical care is provided, in whole or in

part, through a defined set of providers under contract with the insurer, including the financing and delivery of an item paid for as medical care.

[~~(131)~~] (136) "Network provider" means a health care provider who has an agreement with a managed care organization to provide health care services to an enrollee with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly from the managed care organization.

[~~(132)~~] (137) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive a dividend representing a share of the surplus of the insurer.

[~~(133)~~] (138) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

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

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

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

[~~(134)~~] (139) "Order" means an order of the commissioner.

[~~(135)~~] (140) "ORSA guidance manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners and as amended from time to time.

[~~(136)~~] (141) "ORSA summary report" means a confidential high-level summary of an insurer or insurance group's own risk and solvency assessment.

[~~(137)~~] (142) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(138)~~] (143) "Own risk and solvency assessment" means an insurer or insurance group's confidential internal assessment:

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

(ii) of the insurer or insurance group's current business plan to support each risk described in Subsection [~~(138)(a)(i);~~] (143)(a)(i); and

(iii) of the sufficiency of capital resources to support each risk described in

Subsection [~~(138)(a)(i);~~] (143)(a)(i); and

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

[~~(139)~~] (144) "Participating" means a plan of insurance under which the insured is entitled to receive a dividend representing a share of the surplus of the insurer.

[~~(140)~~] (145) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

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

(b) receives:

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

(ii) another government health benefit.

[~~(141)~~] (146) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

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

[~~(142)~~] (147) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

[~~(143)~~] (148) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec. 1002(16)(B).

[~~(144)~~] (149) "Plan year" means:

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection [~~(144)(a)~~] (149)(a) or (b), the calendar year.

[~~(145)~~] (150) (a) "Policy" means a document, including an attached endorsement or application that:

(i) purports to be an enforceable contract; and

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

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

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

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

(iii) a corporation licensed under:

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

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

(c) "Policy" does not include:

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

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

[~~(146)~~] (151) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(147)~~] (152) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy offering life insurance over a period of years.

[~~(148)~~] (153) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(149)~~] (154) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal regulations and guidance.

[~~(150)~~] (155) "Preexisting condition," with respect to health care insurance:

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

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

[~~(151)~~] (156) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

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

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

[~~(152)~~] (157) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(153)~~] (158) "Proceeding" includes an action or special statutory proceeding.

[~~(154)~~] (159) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

[~~(155)~~] (160) (a) "Property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

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

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

[~~(156)~~] (161) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(157)~~] (162) "Qualified United States financial institution" means an institution that:

(a) is:

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

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

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

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

(i) the commissioner by rule; or

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

[~~(158)~~] (163) (a) "Rate" means:

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(159)~~] (164) (a) "Rate service organization" means a person who assists an insurer in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

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

[~~(160)~~] (165) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

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

[~~(161)~~] (166) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow, or give, directly or indirectly:

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

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

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

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

(b) "Rebate" does not include:

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

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

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

[~~(162)~~] (167) "Received by the department" means:

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

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

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

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

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

[~~(163)~~] (168) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

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

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

[~~(164)~~] (169) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(165)~~] (170) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(166)~~] (171) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(167)~~] (172) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

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

[~~(168)~~] (173) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(169)~~] (174) "Scope criteria" means the designated exposure bases and minimum magnitudes for a specified data year that are used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year.

[~~(170)~~] (175) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

[~~(171)~~] (176) (a) "Security" means a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(171)(a)(i)~~] (176)(a)(i) through (xiv); or

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

(b) "Security" does not include:

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

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

[~~(172)~~] (177) "Securityholder" means a specified person who owns a security of a person, including:

(a) common stock;

(b) preferred stock;

(c) debt obligations; and

(d) any other security convertible into or evidencing the right of any of the items listed in this Subsection [~~(172).~~] (177).

[~~(173)~~] (178) (a) "Self-insurance" means an arrangement under which a person provides for spreading the person's own risks by a systematic plan.

(b) "Self-insurance" includes:

(i) an arrangement under which a governmental entity undertakes to indemnify an

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

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

(c) "Self-insurance" does not include:

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

(ii) an arrangement with an independent contractor.

[~~(174)~~] (179) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(175)~~] (180) "Short-term limited duration health insurance" means a health benefit product that:

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

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

[~~(176)~~] (181) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.

[~~(177)~~] (182) (a) "Small employer" means, in connection with a health benefit plan and with respect to a calendar year and to a plan year, an employer who:

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

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

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

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

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

[~~(178)~~] (183) "Special enrollment period," in connection with a health benefit plan, has the

same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.

[~~(179)~~] (184) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(180)~~] (185) Subject to Subsection [~~(92)(b),~~] (95)(b), "surety insurance" includes:

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

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(181)~~] (186) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

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

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

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

(c) "Excess surplus" means:

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

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

(I) 2.5; and

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

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

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(182)~~] (187) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

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

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

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

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

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

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

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

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

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

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

(B) Chapter 26, Insurance Adjusters; and

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

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

(i) that is:

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

(B) a bank or other financial institution that is subject to supervision or examination by a federal or state banking authority; and

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

[~~(183)~~] (188) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(184)~~] (189) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

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

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

[~~(185)~~] (190) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

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

[~~(186)~~] (191) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

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

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

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

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

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

[~~(187)~~] (192) "Underwrite" means the authority to accept or reject risk on behalf of the

insurer.

[~~(188)~~] (193) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage described in Subsection [~~(155).~~] (160).

[~~(189)~~] (194) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

[~~(190)~~] (195) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

[~~(191)~~] (196) "Workers' compensation insurance" means:

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

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

Section 3. Section **31A-2-201.2** is amended to read:

31A-2-201.2 (Effective 05/01/24). Evaluation of health insurance market.

(1) (a) Each year the commissioner shall:

[~~(a)~~] (i) conduct an evaluation of the state's health insurance market;

[~~(b)~~] (ii) report the findings of the evaluation to the [~~Health and Human Services Interim Committee~~] Office of Legislative Research and General Counsel before [~~December 1~~] February 1 of each year; and

[~~(c)~~] (iii) publish the findings of the evaluation on the department website.

(b) After the president of the Senate and the speaker of the House of Representatives appoint members to the Health and Human Services Interim Committee for the year in which the Office of Legislative Research and General Counsel receives a report under this subsection, the Office of Legislative Research and General Counsel shall provide a copy of the report to each member of the committee.

(2) The evaluation required by this section shall:

(a) analyze the effectiveness of the insurance regulations and statutes in promoting a

healthy, competitive health insurance market that meets the needs of the state, and includes an analysis of:

(i) the availability and marketing of individual and group products;

(ii) rate changes;

(iii) coverage and demographic changes;

(iv) benefit trends;

(v) market share changes; and

(vi) accessibility;

(b) assess complaint ratios and trends within the health insurance market, which assessment shall include complaint data from the Office of Consumer Health Assistance within the department;

(c) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes;

(d) include claims loss ratio data for each health insurance company doing business in the state;

(e) include information about pharmacy benefit managers collected under Section 31A-46-301; and

(f) include information, for each health insurance company doing business in the state, regarding:

(i) preauthorization determinations; and

(ii) adverse benefit determinations.

(3) When preparing the evaluation and report required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

(4) The commissioner may adopt administrative rules for the purpose of collecting the data required by this section, taking into account the business confidentiality of the insurers.

(5) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Section 4. Section **31A-2-211** is amended to read:

31A-2-211 (Effective 05/01/24). Rules and forms during transition period.

(1) The commissioner's rules adopted under former Title 31 are rescinded unless continued under Subsection (3).

(2) Between May 1, 1985, and July 1, 1986, the commissioner may prepare and adopt rules

to implement or supplement provisions under Title 31A, Insurance Code. These rules are effective on July 1, 1986, or on the effective date of the particular provision, if that is later than July 1, 1986.

[~~(3) The commissioner may issue orders declaring that all or part of a rule in effect under former Title 31 remains in effect until a date specified under the order, which date may not be later than June 30, 1989. No rule continued under this subsection may be inconsistent with other provisions under Title 31A, Insurance Code. Notice of the order shall be given under Section 31A-2-303.~~]

[~~(4)~~] (3) Every form used, issued, or required by the Insurance Department and approved by the commissioner or otherwise legitimately in use immediately prior to the effective date of this title may continue to be used until replaced in accordance with the provisions of this title.

Section 5. Section **31A-2-215** is amended to read:

31A-2-215 (Effective 05/01/24). Consumer education.

(1) In furtherance of the purposes in Section 31A-1-102, the commissioner may educate consumers about insurance and provide consumer assistance.

(2) Consumer education may include:

(a) outreach activities; and

(b) the production or collection and dissemination of educational materials.

(3) [~~(a)~~] Consumer assistance may include[~~ explaining~~]:

(a) explaining:

(i) the terms of a policy;

(ii) a policy's complaint, grievance, or adverse benefit determination procedure; and

(iii) the fundamentals of self-advocacy[~~.~~] ; and

(b) informal efforts to negotiate a resolution of a dispute between a consumer and a licensee.

(4) (a) Notwithstanding Subsection [~~(3)(a),~~] (3) and Section 31A-2-216, consumer assistance may not include[~~.~~] :

(i) commencing an administrative, judicial, or other proceeding against a licensee to obtain specific relief from the licensee for a specific consumer; or

(ii) [~~testifying or representing a consumer in any grievance or adverse benefit determination, arbitration, judicial, or related proceeding, unless the proceeding is in connection with an enforcement action brought under Section 31A-2-308.~~] otherwise representing a consumer in any administrative, judicial, or other

proceeding.

(5) Nothing in this section prohibits the commissioner from taking enforcement action for violations under Section 31A-2-308.

[~~(4)~~] (6) The commissioner may adopt rules necessary to implement the requirements of this section.

Section 6. Section **31A-2-216** is amended to read:

31A-2-216 (Effective 05/01/24). Office of Consumer Health Assistance.

(1) The commissioner shall establish[~~:~~]

[~~(a)~~] an Office of Consumer Health Assistance before July 1, 1999[~~; and~~] .

[~~(b) a committee to advise the commissioner on consumer assistance rendered under this section.~~]

(2) The office shall:

(a) be a resource for health [~~care~~] insurance consumers concerning health [~~care~~] insurance coverage or the need for such coverage;

(b) help health [~~care~~] insurance consumers understand:

(i) contractual rights and responsibilities;

(ii) statutory protections; and

(iii) available remedies, including adverse benefit determination processes;

(c) educate health [~~care~~] insurance consumers:

(i) by producing or collecting and disseminating educational materials to consumers[~~,~~] and health insurers[~~, and health benefit plans~~]; and

(ii) through outreach and other educational activities;

(d) for health [~~care~~] insurance consumers that have difficulty in accessing their health insurance policies because of language, disability, age, or ethnicity, provide information and services, directly or through referral[~~, such as:~~] ;

[~~(i) information and referral; and~~]

[~~(ii) adverse benefit determination process initiation;~~]

(e) analyze and monitor federal and state consumer health[~~-related~~] insurance statutes, rules, and regulations; and

(f) summarize information gathered under this section and make the summaries available to the public, government agencies, and the Legislature.

(3) The office may:

(a) obtain data from health [~~care~~] insurance consumers as necessary to further the office's duties under this section;

(b) investigate complaints and attempt to resolve complaints at the lowest possible level; and

(c) assist, but not testify or represent, a consumer in an adverse benefit determination, arbitration, judicial, or related proceeding, unless the proceeding is in connection with an enforcement action [~~brought~~]under Section 31A-2-308.

(4) The commissioner may adopt rules necessary to implement the requirements of this section.

Section 7. Section **31A-2-218.1** is enacted to read:

31A-2-218.1 (Effective upon governor's approval). Section 1332 Waiver Study.

(1) As used in this section:

(a) "Secretary" means the secretary of the United States Department of Health and Human Services.

(b) "Section 1332 waiver" means a waiver for state innovation under 45 C.F.R. Part 155, Subpart N.

(2) The commissioner shall conduct a study to determine the feasibility of a state-based program designed to:

(a) lower health benefit plan insurance premiums; and

(b) increase stabilization in the market.

(3) The commissioner, in the study described in Subsection (2), shall create a proposal for a Section 1332 waiver that includes:

(a) a list of provisions the state should seek to waive and the rationale for waiving each provision;

(b) data, assumptions, targets, and other information sufficient to determine that the proposed waiver will provide coverage at least as comprehensive as coverage that would be provided absent the waiver;

(c) coverage and cost sharing protections that keep premiums at least as affordable as would be provided absent the Section 1332 waiver;

(d) actuarial analyses, actuarial certifications, and financial modeling that:

(i) support the estimates that the proposal will comply with the comprehensive coverage requirements, the affordability requirement, the scope of coverage requirement, and the federal deficit requirement; and

(ii) include:

(A) a detailed 10-year budget plan that is deficit-neutral to the federal government;

(B) all costs to the state, including administrative costs, and other costs to the

federal government; and

(C) a detailed analysis regarding the estimated impact of the Section 1332 waiver on health insurance coverage in the state;

(e) proposed legislative changes to provide the state authority to implement the proposed waiver;

(f) implementation plans with a timeline;

(g) categories of covered individuals with high-cost medical conditions who may be reinsured through the proposed waiver, including a recommendation for a multi-year phased-in approach;

(h) reinsurance parameters, including co-insurance, attachment points, or limits;

(i) set premium reduction targets;

(j) a detailed plan for a budget and program implementation; and

(k) a complete application for submission to the secretary.

(4) To carry out the requirements in Subsections (2) and (3) the commissioner may partner or contract with a person that the commissioner determines is appropriate, subject to Title 63G, Chapter 6a, Utah Procurement Code.

(5) On or before November 1, 2024, the commissioner shall submit to the Business and Labor Interim Committee a final written report describing the study described in this section.

Section 8. Section **31A-2-308** is amended to read:

31A-2-308 (Effective 05/01/24). Enforcement penalties and procedures.

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

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

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

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

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

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

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

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

(a) enforcing the commissioner's order;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) intentionally violates:

(A) an insurance statute of this state; or

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

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

(A) an insurance statute of this state; or

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

(iii) intentionally aids any person in violating:

(A) an insurance statute of this state; or

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

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

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

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

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

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

(10) (a) A person who knowingly and intentionally violates Section 31A-4-102,

31A-8a-208, 31A-15-105, 31A-23a-116, or 31A-31-111 is guilty of a felony as provided in this Subsection (10).

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

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

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

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

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

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

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

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

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

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

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

Section 9. Section **31A-4-113.5** is amended to read:

31A-4-113.5 (Effective 05/01/24). Filing requirements -- National Association of Insurance Commissioners.

(1) (a) Each domestic, foreign, and alien insurer who is authorized to transact insurance business in this state shall annually file with the NAIC a copy of the insurer's:

(i) annual statement convention blank on or before March 1;

(ii) market conduct annual statements[~~:~~] on or before the applicable date determined by the NAIC; and

[~~(A) on or before April 30, for all lines of business except health; and~~]

[~~(B) on or before June 30, for the health line of business; and~~]

(iii) any additional filings required by the commissioner for the preceding year.

(b) (i) The information filed with the NAIC under Subsection (1)(a)(i) shall:

(A) be prepared in accordance with the NAIC's:

(I) annual statement instructions; and

(II) Accounting Practices and Procedures Manual; and

(B) include:

(I) the signed jurat page; and

(II) the actuarial certification.

(ii) An insurer shall file with the NAIC amendments and addenda to information filed with the commissioner under Subsection (1)(a)(i).

(c) The information filed with the NAIC under Subsection (1)(a)(ii) shall be prepared in accordance with the NAIC's Market Conduct Annual Statement Industry User Guide.

(d) At the time an insurer makes a filing under this Subsection (1), the insurer shall pay any filing fees assessed by the NAIC.

(e) A foreign insurer that is domiciled in a state that has a law substantially similar to this section shall be considered to be in compliance with this section.

(2) All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the Insurance Regulatory Information System are confidential and may not be disclosed by the department.

(3) The commissioner may suspend, revoke, or refuse to renew the certificate of authority of any insurer failing to:

(a) submit the filings under Subsection (1)(a) when due or within any extension of time granted for good cause by:

(i) the commissioner; or

(ii) the NAIC; or

(b) pay by the time specified in Subsection (3)(a) a fee the insurer is required to pay under this section to:

(i) the commissioner; or

(ii) the NAIC.

Section 10. Section **31A-6a-109** is amended to read:

31A-6a-109 (Effective 05/01/24). Enforcement provisions.

[~~Anyone violating of any of the provisions of this chapter or any rule made pursuant to the grant of rulemaking authority under this title may be assessed an administrative forfeiture equal to two times the amount of any profit gained from~~

~~the violation. In addition an administrative forfeiture may be assessed for each violation not to exceed $1,000 per violation.~~]

(1) If the commissioner finds, as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, that a person has violated any provision of this chapter, the commissioner may take one or more of the following actions:

(a) revoke a registration issued under this chapter;

(b) suspend, for a specified period of 12 months or less, a registration issued under this chapter;

(c) deny an application for a registration under this chapter;

(d) assess a forfeiture equal to two times the amount of any profit gained from the violation; or

(e) assess an additional forfeiture not to exceed $1,000 per violation.

(2) If the violations are continuing, or are of a serious nature, or a person's business practices in connection with the solicitation, sale, offering for sale, or performance under a service contract subject to this chapter, constitute a danger to the legitimate interests of consumers or the public, the commissioner may enjoin the person from soliciting, selling, or offering to sell service contracts in this state either permanently or for a stated period of time.

Section 11. Section **31A-16-102.6** is amended to read:

31A-16-102.6 (Effective 05/01/24). Mutual insurance holding companies.

(1) As used in this section:

(a) "Intermediate holding company" means a holding company that:

(i) is a subsidiary of a mutual insurance holding company;

(ii) directly or through a subsidiary of the holding company, holds one or more subsidiary insurers, including a reorganized mutual insurer; and

(iii) if the subsidiary insurers were not held by the holding company, a majority of the voting shares of the subsidy insurers' capital stock would be required under this section to be owned by the mutual insurance holding company.

(b) "Majority of the voting shares" means the shares of a reorganized mutual insurer's capital stock that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the reorganized mutual insurer's capital stock for the election of directors and other matters submitted to a vote of the reorganized mutual insurer's shareholders.

(2) (a) With the commissioner's approval, a domestic mutual insurer may reorganize by

forming a mutual insurance holding company in which:

(i) in accordance with the mutual insurance holding company's articles of incorporation and bylaws, the membership interests of the domestic mutual insurer's policyholders become membership interests in the mutual insurance holding company; and

(ii) the domestic mutual insurer is reorganized as a domestic stock insurance company.

(b) The commissioner may approve a domestic mutual insurer's reorganization under this Subsection (2) if:

(i) the domestic mutual insurer's reorganization plan:

(A) properly protects the interests of the domestic mutual insurer's policyholders;

(B) is fair and equitable to the domestic mutual insurer's policyholders;[~~and~~]

(C) is approved by a majority of the domestic mutual insurer's policyholders present at any regular or special meeting of the policyholders at which a quorum is present; and

[~~(C)~~] (D) satisfies the requirements of Subsections 31A-16-103(8) through (10);

(ii) the initial shares of the reorganized domestic mutual insurer's capital stock are issued to the mutual insurance holding company or intermediate holding company; and

(iii) at all times, the mutual insurance holding company or intermediate holding company owns a majority of the voting shares of the reorganized domestic mutual insurer's capital stock.

(c) With the commissioner's approval, the mutual insurance holding company may allow in the mutual insurance holding company's articles and bylaws that a policyholder of a stock insurer that is or becomes a subsidiary of the mutual insurance holding company to be a member of the mutual insurance holding company.

(d) The domestic mutual insurer:

(i) shall provide the domestic mutual insurer's policyholders notice of the reorganization plan and the related member meeting by first-class mail;

(ii) shall include in a notice described in Subsection (2)(d)(i), a copy of the full reorganization plan and all related plan materials;

(iii) may satisfy the requirement in Subsection (2)(d)(ii) by including with the notice of reorganization a URL link at which the policyholders can access the full reorganization plan and any related materials electronically; and

(iv) shall provide a physical copy of the reorganization plan and all related plan materials to a policyholder upon request.

(3) (a) With the commissioner's approval, a domestic mutual insurer may reorganize by merging the domestic mutual insurer's policyholders' membership interests into an existing domestic mutual insurance holding company formed under Subsection (2), if:

(i) in accordance with the mutual insurance holding company's articles of incorporation and bylaws, the membership interests of the domestic mutual insurer's policyholders become membership interests in the mutual insurance holding company; and

(ii) the domestic mutual insurer is reorganized as a domestic stock insurance company subsidiary of the existing domestic mutual insurance holding company or intermediate holding company.

(b) The commissioner may approve a domestic mutual insurance company's reorganization under this Subsection (3) if:

(i) the domestic mutual insurer's reorganization plan:

(A) properly protects the interests of the domestic mutual insurer's policyholders;

(B) is fair and equitable to the domestic mutual insurer's policyholders; and

(C) satisfies the requirements of Subsections 31A-16-103(8) through (10);

(ii) all of the initial shares of the capital stock of the reorganized insurance company are issued to the mutual insurance holding company or intermediate holding company; and

(iii) at all times, the mutual insurance holding company or intermediate holding company owns a majority of the voting shares of the reorganized domestic mutual insurer's capital stock.

(c) The commissioner may require, as a condition of approval, any modifications to the proposed merger the commissioner finds necessary for the protection of the policyholders' interests.

[~~(3)~~] (4) (a) With the commissioner's approval, a foreign mutual insurer organized under the laws of any other state that would qualify to become a domestic insurer organized under the laws of this state may reorganize by [~~forming a~~] merging the foreign mutual insurer's policyholders' membership interests into an existing domestic mutual insurance holding company [~~system~~] formed under Subsection (2) in which:

(i) in accordance with the mutual insurance holding company's articles of incorporation and bylaws, the membership interests of the foreign mutual insurer's

policyholders become membership interests in the mutual insurance holding company; and

(ii) the foreign mutual insurer is reorganized as a foreign stock insurance company subsidiary of the existing domestic mutual insurance holding company or intermediate holding company.

(b) The commissioner may approve a foreign mutual insurer's reorganization under this Subsection (4) if:

(i) the foreign mutual insurer's reorganization plan:

(A) complies with any other law or rule applicable to the foreign mutual insurer;

(B) properly protects the interests of the foreign mutual insurer's policyholders;

(C) is fair and equitable to the foreign mutual insurer's policyholders; and

(D) satisfies the requirements of Subsections 31A-16-103(8) through (10);

(ii) all of the initial shares of the reorganized foreign mutual insurer's capital stock are issued to the mutual insurance holding company or intermediate holding company; and

(iii) at all times, the mutual insurance holding company or intermediate holding company owns a majority of the voting shares of the reorganized foreign mutual insurer's capital stock.

(c) After a [~~merger~~] reorganization contemplated by this Subsection (4), the reorganized foreign mutual insurer may:

(i) remain a foreign corporation; and

(ii) with the commissioner's approval, be admitted to conduct business in this state.

(d) A foreign mutual insurer that is a party to a reorganization plan may redomesticate in this state by complying with the applicable requirements of this state and the foreign mutual insurer's state of domicile.

[~~(4)~~] (5) (a) As a condition of approval, the commissioner may require a mutual insurer to modify the mutual insurer's reorganization plan to protect the interests of the mutual insurer's policyholders.

(b) If the commissioner determines reasonably necessary, at the reorganizing mutual insurer's expense, the commissioner may retain a third-party consultant to assist the commissioner in reviewing the mutual insurer's reorganization plan.

(c) The commissioner has jurisdiction over a mutual insurance holding company or intermediate holding company organized in accordance with this section.

(d) Subject to the commissioner's approval, a reorganized mutual insurer or a stock

insurance subsidiary within a mutual insurance company may issue a dividend or distribution to the mutual insurance holding company or intermediate holding company.

[~~(5)~~] (6) (a) Subject to the provisions of this section, a mutual insurance holding company resulting from the reorganization of a domestic mutual insurer shall be incorporated in accordance with and is subject to the provisions of Chapter 5, Domestic Stock and Mutual Insurance Corporations as if it were a mutual insurer.

(b) A mutual insurance holding company's articles of incorporation and bylaws are subject to commissioner's approval in the same manner as an insurance company's articles of incorporation and bylaws.

[~~(6)~~] (7) (a) A mutual insurance holding company is:

(i) subject to Chapter 27a, Insurer Receivership Act; and

(ii) a party to any proceeding under Chapter 27a, Insurer Receivership Act, involving an insurer that is a subsidiary of the mutual insurance holding company as a result of a reorganization in accordance with this section.

(b) In a proceeding under Chapter 27a, Insurer Receivership Act, involving a reorganized mutual insurer, the assets of the mutual insurance holding company are assets of the estate of the reorganized mutual insurer for the purpose of satisfying the claims of the reorganized mutual insurer's policyholders.

(c) A mutual insurance holding company may be dissolved or liquidated only by:

(i) prior approval of the commissioner; or

(ii) court order in accordance with Chapter 27a, Insurer Receivership Act.

[~~(7)~~] (8) (a) Section 31A-5-506 does not apply to a mutual insurer's reorganization or merger under this section.

(b) Section 31A-5-506 applies to demutualization of a mutual insurance holding company.

(c) The following sections do not apply to a mutual insurance holding company:

(i) Sections 31A-5-204 through 31A-5-217.5;

(ii) Sections 31A-5-301 through 31A-5-307;

(iii) Section 31A-5-505; and

(iv) Section 31A-5-509.

(d) Notwithstanding Section 31A-5-203, a mutual insurance holding company is not required to include "insurance" in the mutual insurance holding company's name.

[~~(8)~~] (9) A membership interest in a domestic mutual insurance holding company is not a

security under Utah law.

[~~(9)~~] (10) (a) The ownership of a majority of the voting shares of a reorganized mutual insurer's capital stock includes indirect ownership through one or more intermediate holding companies in a corporate structure approved by the commissioner.

(b) The indirect ownership described in [~~Subsection (9)(a)~~] Subsection (10)(a) may not result in the mutual insurance holding company owning less than the equivalent of the majority of the voting shares of the reorganized mutual insurer's capital stock.

[~~(10)~~] (11) (a) A mutual insurance holding company or intermediate holding company may not sell, transfer, assign, pledge, encumber, hypothecate, alienate, or subject to a security interest or lien the majority of the voting shares of the reorganized mutual insurer's capital stock.

(b) An act that violates [~~Subsection (10)(a)~~] Subsection (11)(a) is void in reverse chronological order of the date the act occurred.

(c) The majority of the voting shares of the reorganized mutual insurer's capital stock are not subject to execution and levy under Utah law.

(d) The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two or more reorganized mutual insurers, or two or more intermediate holding companies that were subsidiaries of the same mutual insurance holding company, are subject to the same requirements, restrictions, and limitations described in this section that applied to the shares of the merging or consolidating reorganized mutual insurers or intermediate holding companies before the merger or consolidation.

[~~(11)~~] (12) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules to implement the provisions of this section.

Section 12. Section **31A-19a-203** is amended to read:

31A-19a-203 (Effective 05/01/24). Rate filings.

(1) (a) Except as provided in Subsections (4) and (5), every authorized insurer and every rate service organization licensed under Section 31A-19a-301 that has been designated by any insurer for the filing of pure premium rates under Subsection 31A-19a-205(2) shall file with the commissioner the following for use in this state:

(i) all rates;

(ii) all supplementary information; and

(iii) all changes and amendments to rates and supplementary information.

(b) An insurer shall file its rates by filing:

(i) its final rates; or

(ii) either of the following to be applied to pure premium rates that have been filed by a rate service organization on behalf of the insurer as permitted by Section 31A-19a-205:

(A) a multiplier; or

(B) (I) a multiplier; and

(II) an expense constant adjustment.

(c) Every filing under this Subsection (1) shall state:

(i) the effective date of the rates; and

(ii) the character and extent of the coverage contemplated.

(d) Except for workers' compensation rates filed under Sections 31A-19a-405 and 31A-19a-406, each filing shall be within 30 days after the rates and supplementary information, changes, and amendments are effective.

(e) A rate filing is considered filed when it has been received[~~:~~]

[~~(i) with the applicable filing fee as prescribed under Section 31A-3-103; and~~]

[~~(ii)~~] pursuant to procedures established by the commissioner.

(f) The commissioner may by rule prescribe procedures for submitting rate filings by electronic means.

(2) (a) To show compliance with Section 31A-19a-201, at the same time as the filing of the rate and supplementary rate information, an insurer shall file all supporting information to be used in support of or in conjunction with a rate.

(b) If the rate filing provides for a modification or revision of a previously filed rate, the insurer is required to file only the supporting information that supports the modification or revision.

(c) If the commissioner determines that the insurer did not file sufficient supporting information, the commissioner shall inform the insurer in writing of the lack of sufficient supporting information.

(d) If the insurer does not provide the necessary supporting information within 45 calendar days of the date on which the commissioner mailed notice under Subsection (2)(c), the rate filing may be:

(i) considered incomplete and unfiled; and

(ii) returned to the insurer as:

(A) not filed; and

(B) not available for use.

(e) Notwithstanding Subsection (2)(d), the commissioner may extend the time period for filing supporting information.

(f) If a rate filing is returned to an insurer as not filed and not available for use under Subsection (2)(d), the insurer may not use the rate filing for any policy issued or renewed on or after 60 calendar days from the date the rate filing was returned.

(3) At the request of the commissioner, an insurer using the services of a rate service organization shall provide a description of the rationale for using the services of the rate service organization, including the insurer's:

(a) own information; and

(b) method of use of the rate service organization's information.

(4) (a) An insurer may not make or issue a contract or policy except in accordance with the rate filings that are in effect for the insurer as provided in this chapter.

(b) Subsection (4)(a) does not apply to contracts or policies for inland marine risks for which filings are not required.

(5) Subsection (1) does not apply to inland marine risks, which, by general custom, are not written according to standardized manual rules or rating plans.

(6) (a) The insurer may file a written application, stating the insurer's reasons for using a higher rate than that otherwise applicable to a specific risk.

(b) If the application described in Subsection (6)(a) is filed with and not disapproved by the commissioner within 10 days after filing, the higher rate may be applied to the specific risk.

(c) The rate described in this Subsection (6) may be disapproved without a hearing.

(d) If disapproved, the rate otherwise applicable applies from the effective date of the policy, but the insurer may cancel the policy pro rata on 10 days' notice to the policyholder.

(e) If the insurer does not cancel the policy under Subsection (6)(d), the insurer shall refund any excess premium from the effective date of the policy.

(7) (a) Agreements may be made between insurers on the use of reasonable rate modifications for insurance provided under Section 31A-22-310.

(b) The rate modifications described in Subsection (7)(a) shall be filed immediately upon agreement by the insurers.

Section 13. Section **31A-19a-209** is amended to read:

31A-19a-209 (Effective 05/01/24). Special provisions for title insurance.

(1) (a) (i) The Title and Escrow Commission may make rules, in accordance with

Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and subject to Section 31A-2-404, establishing rate standards and rating methods.

(ii) The commissioner shall determine compliance with rate standards and rating methods for title insurers, individual title insurance producers, and agency title insurance producers.

(b) In addition to the considerations in determining compliance with rate standards and rating methods as set forth in Sections 31A-19a-201 and 31A-19a-202, including for title insurers, the commissioner and the Title and Escrow Commission shall consider the costs and expenses incurred by title insurers, individual title insurance producers, and agency title insurance producers pertaining to the business of title insurance including:

(i) the maintenance of title plants; and

(ii) the examining of public records to determine insurability of title to real property.

(2) A title insurer[~~, individual title insurance producer, or agency title insurance producer~~] may not use any rate or other charge relating to the business of title insurance[~~, including rates or charges for escrow~~] that would cause the title [~~insurance company, individual title insurance producer, or agency title insurance producer to:~~] insurer to fail to adequately underwrite a title insurance policy. [~~(a) operate at less than the cost of doing the insurance business; or~~]

[~~(b) fail to adequately underwrite a title insurance policy.~~]

Section 14. Section **31A-20-108** is amended to read:

31A-20-108 (Effective 05/01/24). Single risk limitation.

(1) This section applies to all lines of insurance, including ocean marine and reinsurance, except:

(a) title insurance;

(b) workers' compensation insurance;

(c) occupational disease insurance;

(d) employers' liability insurance; and

(e) health insurance.

(2) (a) Except as provided under Subsections (3) and (4) and under Section 31A-20-109, an insurer authorized to do an insurance business in Utah may not expose itself to loss on a single risk in an amount exceeding 10% of its capital and surplus.

(b) The commissioner may adopt rules to calculate surplus under this section.

(c) An insurer may deduct the portion of a risk reinsured by a reinsurance contract

worthy of a reserve credit under Sections 31A-17-404 through 31A-17-404.4 in determining the limitation of risk under this section.

(3) (a) The commissioner may adopt rules, after hearings held with notice [~~provided under Section 31A-2-303~~] as required by law, to specify the maximum exposure to which an assessable mutual may subject itself.

(b) The rules described in Subsection (3)(a) may provide for classifications of insurance and insurers to preserve the solidity of insurers.

(4) As used in this section, a "single risk" includes all losses reasonably expected as a result of the same event.

(5) A company transacting fidelity or surety insurance may expose itself to a risk or hazard in excess of the amount prescribed in Subsection (2), if the commissioner, after considering all the facts and circumstances, approves the risk.

Section 15. Section **31A-21-316** is amended to read:

31A-21-316 (Effective 05/01/24). Electronic notices and documents.

(1) As used in this section:

(a) "Delivered by electronic means" includes:

(i) delivery to an electronic mail address at which a party has consented to receive a notice or document; or

(ii) posting on an electronic network or site accessible by way of the Internet, a mobile application, a computer, a mobile device, a tablet, or any other electronic device, together with separate notice of the posting that is provided by:

(A) electronic mail to the address at which the party has consented to receive notice; or

(B) any other delivery method that has been consented to by the party.

(b) (i) "Party" means a recipient of a notice or document required as part of an insurance transaction.

(ii) "Party" includes an applicant, an insured, or a policyholder.

(c) "Policy document" means a policy, certificate, amendment, or endorsement.

(2) Subject to [~~Subsection (4)~~] Subsections (4) and (5), a notice to a party or another document required under applicable law in an insurance transaction or that serves as evidence of insurance coverage may be delivered, stored, and presented by electronic means if it meets the requirements of Title 46, Chapter 4, Uniform Electronic Transactions Act.

(3) Delivery of a notice or document in accordance with this section is considered

equivalent to any delivery method required under applicable law.

(4) [~~Subject to Subsection (5), a~~] A notice or document may be delivered by electronic means by an insurer to a party under this section if:

(a) the party has affirmatively consented to that method of delivery and has not withdrawn the consent;

(b) the party, before giving consent, is provided with a clear and conspicuous statement informing the party of:

(i) any right or option of the party to have the notice or document provided or made available in paper or another nonelectronic form;

(ii) the right of the party to withdraw consent to have a notice or document delivered by electronic means, including:

(A) a condition or consequence imposed if consent is withdrawn;

(B) when the insurer will make the party's withdrawal effective, during or at the conclusion of the policy term; and

(C) the procedure a party is to follow to withdraw consent to have a notice or document delivered by electronic means;

(iii) whether the party's consent applies:

(A) only to the particular transaction as to which the notice or document must be given; or

(B) to identified categories of notices or documents that may be delivered by electronic means during the course of the party's relationship with the insured; and

(iv) the means, after consent is given, by which a party may obtain a paper copy of a notice or document delivered by electronic means; and

(c) the party:

(i) before giving consent, is provided with a statement of the electronic delivery and retrieval method requirements for access to and retention of a notice or document delivered by electronic means;

(ii) consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for a notice or document delivered by electronic means as to which the party has given consent; and

(iii) is provided a process to update information needed to contact the party electronically[~~.~~] ;

[~~(5)~~] (d) [~~(a) After~~] after consent of the party is given and if a change in the electronic delivery or retrieval methods creates a substantial risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies, the insurer[~~ shall~~]:

(i) [~~provide~~] provides the party with a statement of:

(A) the revised electronic delivery or retrieval methods; and

(B) the right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed under Subsection (4)(b)(ii);[~~ and~~]

(ii) [~~comply~~] complies with Subsection (4)(b)[~~.~~] ; and

[~~(b) Failure by an insurer to comply with this Subsection (5) is treated, at the election of the party, as a withdrawal of consent for purposes of this section.~~]

[~~(c) When an electronic mail address provided by the party to facilitate delivery by electronic means is returned with a message as undeliverable each time electronic delivery is attempted over a period not to exceed two business days, the party is presumed to have withdrawn consent for the purposes of this section.~~]

[~~(d)~~]

[~~(i)~~] (e) [~~An~~] an insurer [~~shall file~~] files with the department the consent statement described under Subsection (4)(b), which includes conditions or consequences for a party to revoke the party's consent to conduct an insurance transaction, electronically.

[~~(ii)~~] (i) An insurer shall file the consent statement described in [~~Subsection (5)(d)(i)~~] Subsection (4)(b) before the insurer uses the consent statement.

[~~(iii)~~] (ii) The insurer shall communicate to the party in accordance with Subsection (4)(b) the conditions or consequences for a party to revoke the party's consent.

(5) (a) An insurer may deliver a policy document to a party, by electronic means and without the party's consent to receive the policy document by electronic means, if:

(i) the party has not withdrawn the consent described in this Subsection (5);

(ii) the insurer provides a clear and conspicuous statement in paper form, to the party, informing the party of:

(A) the party's right or option to have the policy document provided or made available in paper or another nonelectronic form;

(B) the party's right to withdraw consent to the electronic delivery of a policy document, including the procedure a party must follow to withdraw consent to electronic delivery of a policy document;

(C) policy documents that the insurer may deliver electronically;

(D) the means by which a party may obtain a paper copy of a policy document that the insurer delivered electronically;

(E) the electronic delivery and retrieval method requirements for access to and retention of a policy document delivered electronically; and

(F) the process to update the party's electronic contact information; and

(iii) the party demonstrates the ability to electronically access the information contained in the policy document.

(b) This Subsection (5) does not apply to a life insurance policy document.

(6) A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

(7) This section does not affect requirements related to content or timing of any notice or document required under applicable law.

(8) If a provision of this title or applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(9) The legal effectiveness, validity, or enforceability of a contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with Subsection (4)(c)(ii).

(10) This section does not apply to or affect a notice or document delivered by an insurer in an electronic form before July 1, 2014, to a party who, before July 1, 2014, has consented to receive the notice or document in an electronic form otherwise allowed by law.

(11) If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before July 1, 2014, and pursuant to this section, an insurer intends to deliver an additional notice or document to the party in an electronic form, then before delivering the additional notices or documents electronically, the insurer shall notify the party of:

(a) the notices or documents that may be delivered by electronic means under this section that were not previously delivered electronically; and

(b) the party's right to withdraw consent to have notices or documents delivered by electronic means.

(12) (a) Except as otherwise provided by Section 31A-21-102, if an oral communication or a recording of an oral communication from a party can be reliably stored and reproduced by an insurer, the oral communication or recording may qualify as a notice or document delivered by electronic means for purposes of this section.

(b) If a provision of this title or applicable law requires a signature, notice, or document to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if the electronic signature of the party authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the signature, notice, or document.

(13) For purposes of this section, an insurer's failure to comply with Subsection (4) or (5) constitutes a withdrawal of the party's consent.

(14) A party is presumed to have withdrawn consent under this section if the email address the party provides to receive a policy document returns a message stating that the message is undeliverable each time the insurer attempts electronic delivery over a period of up to two business days.

[~~(13)~~] (15) This section may not be construed to modify, limit, or supersede the federal Electronic Signatures in Global and National Commerce Act, P. Law 106-229, as amended.

Section 16. Section **31A-21-402** is amended to read:

31A-21-402 (Effective 05/01/24). Definitions.

[~~As used in this part:~~]

[~~(1) (a) "Direct response solicitation" means any offer an insurer makes to persons in this state, either directly or through a third party, to effect life or accident and health insurance coverage which enables the individual to apply or enroll for the insurance on the basis of the offer.~~]

[~~(b) "Direct response solicitation" does not include:~~]

[~~(i) solicitations for insurance through an employee benefit plan exempt from state regulation under preemptive federal law; or~~]

[~~(ii) solicitations through an individual's creditor with respect to credit life or credit accident and health insurance. (2) "Mass~~] As used in this part, "mass marketed life or accident and health insurance" means the insurance under any individual, franchise, group, or blanket insurance policy offering life or accident and health insurance:

[~~(a)~~] (1) that is offered by means of direct response solicitation through:

[~~(i)~~] (a) a sponsoring organization; or

[~~(ii)~~] (b) the mails or other mass communications media; and

[~~(b)~~] (2) under which the person insured pays all or substantially all of the cost of the person's insurance.

Section 17. Section **31A-22-401** is amended to read:

31A-22-401 (Effective 05/01/24). Prohibited life insurance policy provisions.

No life insurance company may issue or deliver any life insurance policy subject to this chapter under Section 31A-21-101 which contains any provision:

(1) forfeiting the policy for failure to repay any loan on the policy or to pay interest on the loan while the total indebtedness on the policy is less than its loan value, and in ascertaining the indebtedness due upon policy loans, the interest, if not paid when due, may be added to the principal of those loans and may bear interest at the same rate as the principal;

(2) claiming that the policy was issued or became effective more than one year before the original application for the insurance is executed, if the insured would then be rated at an age more than one year younger than his age at the date of his application, unless the aggregate amount of the annual premiums for the whole term of the back-dated period is paid in cash;[~~or~~]

(3) allowing assessments or calls to be made upon policyholders[~~.~~] ; or

(4) allowing an insurer to cancel or terminate a policy for a reason other than:

(a) nonpayment of a premium when due; or

(b) as allowed pursuant to Subsection 31A-21-105(2).

Section 18. Section **31A-22-605** is amended to read:

31A-22-605 (Effective 05/01/24). Accident and health insurance standards.

(1) The purposes of this section include:

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

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

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

contracts.

[~~(2) As used in this section:~~]

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

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

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

[~~(3)~~] (2) This section applies to all individual and franchise accident and health policies.

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

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

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage provisions;

(iv) coverage of dependents;

(v) preexisting conditions;

(vi) termination of insurance;

(vii) probationary periods;

(viii) limitations;

(ix) exceptions;

(x) reductions;

(xi) elimination periods;

(xii) requirements for replacement;

(xiii) recurrent conditions;

(xiv) coverage of persons eligible for Medicare; and

(xv) definition of terms;

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

(i) basic hospital expense coverage;

(ii) basic medical-surgical expense coverage;

(iii) hospital confinement indemnity coverage;

(iv) major medical expense coverage;

(v) income replacement coverage;

(vi) accident only coverage;

(vii) specified disease or specified accident coverage;

(viii) limited benefit health coverage; and

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

(c) the content and format of the outline of coverage, in addition to that required under Subsection [~~(6);~~] (5);

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

(e) rating practices.

[~~(5)~~] (4) Nothing in Subsection [~~(4)(b)~~] (3)(b) precludes the issuance of policies that combine categories of coverage in Subsection [~~(4)(b)~~] (3)(b) provided that any combination of categories meets the standards of a component category of coverage.

[~~(6)~~] (5) The commissioner may adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, relating to the following matters:

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

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

(ii) applying the requirements of Subsection [~~(6)(b)(i) apply~~] (5)(b)(i) to all insurance policies and certificates sold to persons eligible for Medicare; and

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

[~~(7)~~] (6) A policy covered by this section may be issued only if it meets the minimum standards established by the commissioner under Subsection [~~(4),~~] (3), an outline of coverage accompanies the policy or is delivered to the applicant at the time of the application, and, except with respect to direct response insurance policies, an acknowledged receipt is provided to the insurer. The outline of coverage shall include:

(a) a statement identifying the applicable categories of coverage provided by the policy

as prescribed under Subsection [~~(4);~~] (3);

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

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

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

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

(f) any other contents the commissioner prescribes.

[~~(8)~~] (7) If a policy is issued on a basis other than that applied for, the outline of coverage shall accompany the policy when it is delivered and it shall clearly state that it is not the policy for which application was made.

[~~(9)~~] (8) (a) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or certificates issued to persons eligible for Medicare shall contain a notice prominently printed on or attached to the cover or front page which states that the policyholder or certificate holder has the right to return the policy for any reason within 30 days after its delivery and to have the premium refunded.

(b) This Subsection [~~(9)~~] (8) does not apply to a policy issued to an employer group.

Section 19. Section **31A-22-614** is amended to read:

31A-22-614 (Effective 07/01/24). Claims under accident and health policies.

(1) Section 31A-21-312 applies generally to claims under accident and health policies.

(2) (a) Subject to Subsection (1), an accident and health insurance policy may not contain a claim notice requirement less favorable to the insured, or an insured's network provider, than one which requires written notice of the claim within 20 days after the occurrence or commencement of any loss covered by the policy. The policy shall specify to whom claim notices may be given.

(b) If a loss of time benefit under a policy may be paid for a period of at least two years, an insurer may require periodic notices that the insured continues to have a disability, unless the insured is legally incapacitated. The insured's, or the insured's network provider's, delay in giving that notice does not impair the insured's, the insured's network provider's, or beneficiary's right to any indemnity which would otherwise have accrued during the six months preceding the date on which that notice is actually given.

(3) An accident and health insurance policy may not contain a time limit on proof of loss which is more restrictive to the insured, or the insured's network provider, than a

provision requiring written proof of loss, delivered to the insurer, within the following time:

(a) for a claim where periodic payments are contingent upon continuing loss, within [~~90~~] 120 days after the termination of the period for which the insurer is liable; or

(b) for any other claim, within [~~90~~] 120 days after the date of the loss.

(4) (a) (i) Section 31A-26-301 applies generally to the payment of claims.

(ii) Indemnity for loss of life is paid in accordance with the beneficiary designation effective at the time of payment. If no valid beneficiary designation exists, the indemnity is paid to the insured's estate. Any other accrued indemnities unpaid at the insured's death are paid to the insured's estate.

(b) Reasonable facility of payment clauses, specified by the commissioner by rule or in approving the policy form, are permitted. Payment made in good faith and in accordance with those clauses discharges the insurer's obligation to pay those claims.

(c) All or a portion of any indemnities provided under an accident and health policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering the services.

Section 20. Section **31A-22-620** is amended to read:

31A-22-620 (Effective 05/01/24). Medicare Supplement Insurance Minimum Standards Act.

(1) As used in this section:

(a) "Applicant" means:

(i) in the case of an individual Medicare supplement insurance policy, the person who seeks to contract for insurance benefits; and

(ii) in the case of a group Medicare supplement insurance policy, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement insurance policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering, or issuing for delivery in this state, Medicare supplement insurance policies or certificates.

[~~(e) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.~~]

[~~(f) "Medicare Supplement Policy":~~]

[~~(i) means a group or individual policy of health insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Sec. 1395 et seq., or an issued policy under a demonstration project specified in 42 U.S.C. Sec. 1395ss(g)(1), that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare; and~~]

[~~(ii) does not include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan that provides benefits pursuant to an agreement under Section 1833(a)(1)~~]

[~~(A) of the Social Security Act.~~]

[~~(g)~~] (e) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(2) (a) Except as otherwise specifically provided, this section applies to:

(i) all Medicare supplement insurance policies delivered or issued for delivery in this state on or after the effective date of this section;

(ii) all certificates issued under group Medicare supplement insurance policies, that have been delivered or issued for delivery in this state on or after the effective date of this section; and

(iii) policies or certificates that were in force prior to the effective date of this section, with respect to requirements for benefits, claims payment, and policy reporting practice under Subsection (3)(d), and loss ratios under Subsection (4).

(b) This section does not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers and labor unions, for employees or former employees or a combination of employees and former employees, or for members or former members of the labor organizations, or a combination of members and former members of labor organizations.

(c) This section does not prohibit, nor does it apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held out to be Medicare supplement insurance policies or benefit plans.

(3) (a) A Medicare supplement insurance policy or certificate in force in the state may

not contain benefits that duplicate benefits provided by Medicare.

(b) Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate may not exclude or limit benefits for loss incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than: "A condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage."

(c) The commissioner shall adopt rules to establish specific standards for policy provisions of Medicare supplement insurance policies and certificates. The standards adopted shall be in addition to and in accordance with applicable laws of this state. A requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this section, may not apply to Medicare supplement insurance policies and certificates. The standards may include:

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage;

(iv) probationary periods;

(v) benefit limitations, exceptions, and reductions;

(vi) elimination periods;

(vii) requirements for replacement;

(viii) recurrent conditions; and

(ix) definitions of terms.

(d) The commissioner shall adopt rules establishing minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement insurance policies and certificates.

(e) The commissioner may adopt rules to conform Medicare supplement insurance policies and certificates to the requirements of federal law and regulations, including:

(i) requiring refunds or credits if the policies do not meet loss ratio requirements;

(ii) establishing a uniform methodology for calculating and reporting loss ratios;

(iii) assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance;

(iv) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(v) establishing a policy for holding public hearings prior to approval of premium increases;

(vi) establishing standards for Medicare select policies and certificates; and

(vii) nondiscrimination for genetic testing or genetic information.

(f) The commissioner may adopt rules that prohibit policy provisions not otherwise specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement insurance policy or certificate.

(4) Medicare supplement insurance policies shall return to policyholders benefits that are reasonable in relation to the premium charged. The commissioner shall make rules to establish minimum standards for loss ratios of Medicare supplement insurance policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service basis rather than on a reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

(5) (a) To provide for full and fair disclosure in the sale of [~~Medicare supplement policies, a Medicare supplement policy~~] Medicare supplement insurance, a Medicare supplement insurance policy or certificate may not be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The commissioner shall prescribe the format and content of the outline of coverage required by Subsection (5)(a).

(c) For purposes of this section, "format" means style arrangements and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage shall include:

(i) a description of the principal benefits and coverage provided in the policy;

(ii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

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

(d) The commissioner may make rules for captions or notice if the commissioner finds that the rules are:

(i) in the public interest; and

(ii) designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare, other than:

(A) a [~~medicare~~] Medicare supplement insurance policy; or

(B) a disability income policy.

(e) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, that is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the informational brochure be provided concurrently with delivery of the outline of coverage to any prospective insureds eligible for Medicare. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(f) The commissioner may adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and health policies, subscriber contracts, or certificates by persons eligible for Medicare.

(6) Notwithstanding Subsection (1), Medicare supplement insurance policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached to the front page, stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

(7) Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement insurance advertisement intended for use in this state, whether through written or broadcast medium, to the commissioner for review.

(8) The commissioner may adopt rules to conform Medicare and Medicare supplement insurance policies and certificates to the marketing requirements of federal law and regulation.

Section 21. Section **31A-22-802** is amended to read:

31A-22-802 (Effective 05/01/24). Definitions.

As used in this part:

[~~(1) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor has a disability.~~]

[~~(2) "Credit life insurance" means life insurance on the life of a debtor in connection with a specific loan or credit transaction.~~]

[~~(3)~~] (1) "Credit transaction" means any transaction under which the payment for money loaned or for goods, services, or properties sold or leased is to be made on future dates.

[~~(4)~~] (2) "Creditor" means the lender of money or the vendor or lessor of goods, services, or property, for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of any lender or vendor.

[~~(5)~~] (3) "Debtor" means a borrower of money or a purchaser, including a lessee under a lease intended as security, of goods, services, or property, for which payment is arranged through a credit transaction.

[~~(6)~~] (4) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a credit transaction, including principal finance charges and interest.

[~~(7)~~] (5) "Net indebtedness" means the total amount required to liquidate the indebtedness, exclusive of any unearned interest, any insurance on the monthly outstanding balance coverage, or any finance charge.

[~~(8)~~] (6) "Net written premiums" means gross written premiums minus refunds on termination.

Section 22. Section **31A-22-2002** is amended to read:

31A-22-2002 (Effective 05/01/24). Definitions.

As used in this part:

(1) "Applicant" means:

(a) when referring to an individual limited long-term care insurance policy, the person who seeks to contract for benefits; and

(b) when referring to a group limited long-term care insurance policy, the proposed certificate holder.

(2) "Elimination period" means the length of time between meeting the eligibility for benefit payment and receiving benefit payments from an insurer.

(3) "Group limited long-term care insurance" means a limited long-term care insurance policy that is delivered or issued for delivery:

(a) in this state; and

(b) to an eligible group, as described under Subsection [~~31A-22-701(2)~~] 31A-22-701(1).

(4) (a) "Limited long-term care insurance" means an insurance policy, endorsement, or rider that is advertised, marketed, offered, or designed to provide coverage:

(i) for less than 12 consecutive months for each covered person;

(ii) on an expense-incurred, indemnity, prepaid or other basis; and

(iii) for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services that is provided in a setting other than an acute care unit of a hospital.

(b) "Limited long-term care insurance" includes a policy or rider described in Subsection (4)(a) that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

(c) "Limited long-term care insurance" does not include an insurance policy that is offered primarily to provide:

(i) basic Medicare supplement insurance coverage;

(ii) basic hospital expense coverage;

(iii) basic medical-surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accidental only coverage;

(viii) specified disease or specified accident coverage; or

(ix) limited benefit health coverage.

(5) "Preexisting condition" means a condition for which medical advice or treatment is recommended:

(a) by, or received from, a provider of health care services; and

(b) within six months before the day on which the coverage of an insured person becomes effective.

(6) "Waiting period" means the time an insured waits before some or all of the insured's coverage becomes effective.

Section 23. Section **31A-23a-105** is amended to read:

31A-23a-105 (Effective 05/01/24). General requirements for individual and agency license issuance and renewal.

(1) (a) The commissioner shall issue or renew a license to a person described in Subsection (1)(b) to act as:

(i) a producer;

(ii) a surplus lines producer;

(iii) a limited line producer;

(iv) a consultant;

(v) a managing general agent; or

(vi) a reinsurance intermediary.

(b) The commissioner shall issue or renew a license under Subsection (1)(a) to a person who, as to the license type and line of authority classification applied for under Section 31A-23a-106:

(i) satisfies the application requirements under Section 31A-23a-104;

(ii) satisfies the character requirements under Section 31A-23a-107;

(iii) satisfies applicable continuing education requirements under Section 31A-23a-202;

(iv) satisfies applicable examination requirements under Section 31A-23a-108;

(v) satisfies applicable training period requirements under Section 31A-23a-203;

(vi) if an applicant for a resident individual producer license, certifies that, to the extent applicable, the applicant:

(A) is in compliance with Section 31A-23a-203.5; and

(B) will maintain compliance with Section 31A-23a-203.5 during the period for which the license is issued or renewed;

(vii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23a-111;

(viii) if a nonresident:

(A) complies with Section 31A-23a-109; and

(B) holds an active similar license in that person's home state;

(ix) if an applicant for an individual title insurance producer or agency title insurance producer license, satisfies the requirements of Section 31A-23a-204;

(x) if an applicant for a license to act as a life settlement provider or life settlement producer, satisfies the requirements of Section 31A-23a-117; and

(xi) pays the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for a pending:

(A) individual or agency producer license;

(B) surplus lines producer license;

(C) limited line producer license;

(D) consultant license;

(E) managing general agent license; or

(F) reinsurance intermediary license; or

(ii) a licensed:

(A) individual or agency producer;

(B) surplus lines producer;

(C) limited line producer;

(D) consultant;

(E) managing general agent; or

(F) reinsurance intermediary.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) an administrative action taken against the person, including a denial of a new or renewal license application:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state;[~~and~~]

(ii) a criminal prosecution taken against the person in any jurisdiction[~~.~~] ; and

(iii) a civil action filed against the person in any jurisdiction if the action involves conduct related to a professional or occupational license, certification, authorization, or registration, regardless of whether the person held the license, certification, authorization, or registration.

(c) The report required by Subsection (2)(b) shall:

(i) be filed:

(A) at the time the person files the application for an individual or agency license; and

(B) for an action or prosecution that occurs on or after the day on which the person files the application:

(I) for an administrative action, within 30 days of the final disposition of the administrative action; or

(II) for a criminal prosecution or civil action, within 30 days of the initial appearance before a court; and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).

(3) (a) The department may require a person applying for a license or for consent to engage in the business of insurance to submit to a criminal background check as a

condition of receiving a license or consent.

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(d) Information obtained by the department from the review of criminal history records received under this Subsection (3) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-23a-107 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-23a-107; and

(iii) preventing a person who violates the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in the state.

(e) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(c)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(c)(ii); and

(iii) charge the person applying for a license or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).

(4) To become a resident licensee in accordance with Section 31A-23a-104 and this section, a person licensed as one of the following in another state who moves to this state shall

apply within 90 days of establishing legal residence in this state:

(a) insurance producer;

(b) surplus lines producer;

(c) limited line producer;

(d) consultant;

(e) managing general agent; or

(f) reinsurance intermediary.

(5) (a) The commissioner may deny a license application for a license listed in Subsection (5)(b) if the person applying for the license, as to the license type and line of authority classification applied for under Section 31A-23a-106:

(i) fails to satisfy the requirements as set forth in this section; or

(ii) commits an act that is grounds for denial, suspension, or revocation as set forth in Section 31A-23a-111.

(b) This Subsection (5) applies to the following licenses:

(i) producer;

(ii) surplus lines producer;

(iii) limited line producer;

(iv) consultant;

(v) managing general agent; or

(vi) reinsurance intermediary.

(6) Notwithstanding the other provisions of this section, the commissioner may:

(a) issue a license to an applicant for a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission; and

(b) renew a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission.

Section 24. Section **31A-23a-111** is amended to read:

31A-23a-111 (Effective 05/01/24). Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.

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

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

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

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

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

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

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

(e) voluntarily surrendered.

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

(a) a lapsed license; or

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

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

(a) this title; or

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

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

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

(b) the supporting license type:

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

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

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

(iv) is voluntarily surrendered; or

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

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

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

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

(i) revoke:

(A) a license; or

(B) a line of authority;

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

(A) a license; or

(B) a line of authority;

(iii) limit in whole or in part:

(A) a license; or

(B) a line of authority;

(iv) deny a license application;

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

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

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee or license applicant:

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

(ii) violates:

(A) an insurance statute;

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

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

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

(iv) [~~fails to pay a final judgment rendered against the person within 60 days after the day on which the judgment became final~~] is more than 60 days past due on an enforceable final judgment;

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

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

(vii) refuses:

(A) to be examined; or

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

(viii) has an officer who refuses to:

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

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

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

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

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

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

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

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

(A) insurance contract;

(B) application for insurance; or

(C) life settlement;

(xiv) has been convicted of, or has entered a plea in abeyance as defined in Section 77-2a-1 to:

(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;

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

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

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

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

(xvii) has had an insurance license or other professional or occupational license, or an equivalent to an insurance license or registration, or other professional or occupational license or registration:

(A) denied;

(B) suspended;

(C) revoked; or

(D) surrendered to resolve an administrative action;

(xviii) forges another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) improperly uses notes or another reference material to complete an examination

for an insurance license;

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

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

(xxii) fails to:

(A) pay state income tax; or

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

(xxiii) has been convicted of violating the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;

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

(xxv) has been convicted of any criminal felony involving dishonesty or breach of trust and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033.

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

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

(i) the individual;

(ii) the agency, if the agency:

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

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

(iii) (A) the individual; and

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

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

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

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

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

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

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

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

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

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

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

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

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

Section 25. Section **31A-23a-119** is enacted to read:

31A-23a-119 (Effective 05/01/24). Special requirements for agency title insurance producers.

(1) As used in this section:

(a) "Applicable percentage" means:

(i) on February 1, 2024, through January 31, 2025, 2.5%;

(ii) on February 1, 2025, through January 31, 2026, 3%;

(iii) on February 1, 2026, through January 31, 2027, 3.5%;

(iv) on February 1, 2027, through January 31, 2028, 4%; and

(v) on February 1, 2028, through January 31, 2029, 4.5%.

(b) "Sufficient capital and net worth" means:

(i) for a new title entity:

(A) $100,000 for the first five years after becoming a new agency title insurance producer; or

(B) after the first five years after becoming a new agency title insurance producer, the greater of $50,000, or on February 1 of each year, an amount equal to 5% of the title entity's average annual gross revenue over the preceding two calendar years, up to $150,000; or

(ii) for a title entity licensed before May 14, 2019:

(A) for the time period beginning on February 1, 2020, and ending on January 31, 2029, the lesser of an amount equal to the applicable percentage of the title entity's average annual gross revenue over the two calendar years immediately preceding the February 1 on which the applicable percentage applies or $150,000; and

(B) beginning on February 1, 2029, the greater of $50,000 or an amount equal to 5% of the title entity's average annual gross revenue over the preceding two calendar years, up to $150,000.

(2) Before May 1 of each year, each agency title insurance producer shall submit a report to the commissioner containing proof satisfactory to the commissioner that the agency title insurance producer had sufficient capital and net worth for the preceding calendar year.

Section 26. Section **31A-23a-406** is amended to read:

31A-23a-406 (Effective 05/01/24). Title insurance producer's business.

(1) As used in this section:

(a) "Automated clearing house network" or "ACH network" means a national electronic funds transfer system regulated by the Federal Reserve and the Office of the Comptroller of the Currency.

(b) "Depository institution" means the same as that term is defined in Section 7-1-103.

(c) "Funds transfer system" means the same as that term is defined in Section [~~7-1-103.~~]

70A-4a-105.

(2) An individual title insurance producer or agency title insurance producer may do escrow involving real property transactions if all of the following exist:

(a) the individual title insurance producer or agency title insurance producer is licensed with:

(i) the title line of authority; and

(ii) the escrow subline of authority;

(b) the individual title insurance producer or agency title insurance producer is appointed by a title insurer authorized to do business in the state;

(c) except as provided in Subsection (4), the individual title insurance producer or agency title insurance producer issues one or more of the following as part of the transaction:

(i) an owner's policy offering title insurance;

(ii) a lender's policy offering title insurance; or

(iii) if the transaction does not involve a transfer of ownership, an endorsement to an owner's or a lender's policy offering title insurance;

(d) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow is deposited:

(i) in a federally insured depository institution, as defined in Section 7-1-103, that:

(A) has a branch in this state, if the individual title insurance producer or agency title insurance producer depositing the money is a resident licensee; and

(B) is authorized by the depository institution's primary regulator to engage in trust business, as defined in Section 7-5-1, in this state; and

(ii) in a trust account that is separate from all other trust account money that is not related to real estate transactions;

(e) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow is the property of the one or more persons entitled to the money under the provisions of the escrow;

(f) money deposited with the individual title insurance producer or agency title insurance producer in connection with an escrow is segregated escrow by escrow in the records of the individual title insurance producer or agency title insurance producer;

(g) earnings on money held in escrow may be paid out of the [~~escrow~~] trust account to any person in accordance with the conditions of the escrow;

(h) the escrow does not require the individual title insurance producer or agency title

insurance producer to hold:

(i) construction money; or

(ii) money held for exchange under Section 1031, Internal Revenue Code; and

(i) the individual title insurance producer or agency title insurance producer shall maintain a physical office in Utah staffed by a person with an escrow subline of authority who processes the escrow.

(3) Notwithstanding Subsection (2), an individual title insurance producer or agency title insurance producer may engage in the escrow business if:

(a) the escrow involves:

(i) a mobile home;

(ii) a grazing right;

(iii) a water right; or

(iv) other personal property authorized by the commissioner; and

(b) the individual title insurance producer or agency title insurance producer complies with this section except for Subsection (2)(c).

(4) (a) Subsection (2)(c) does not apply if the transaction is for the transfer of real property from the School and Institutional Trust Lands Administration.

(b) This subsection does not prohibit an individual title insurance producer or agency title insurance producer from issuing a policy described in Subsection (2)(c) as part of a transaction described in Subsection (4)(a).

(5) Money held in escrow:

(a) is not subject to any debts of the individual title insurance producer or agency title insurance producer;

(b) may only be used to fulfill the terms of the individual escrow under which the money is accepted; and

(c) may not be used until the conditions of the escrow are met.

(6) Assets or property other than escrow money received by an individual title insurance producer or agency title insurance producer in accordance with an escrow shall be maintained in a manner that will:

(a) reasonably preserve and protect the asset or property from loss, theft, or damages; and

(b) otherwise comply with the general duties and responsibilities of a fiduciary or bailee.

(7) (a) A check from the trust account described in Subsection (2)(d) may not be drawn, executed, or dated, or money otherwise disbursed unless the segregated [~~escrow~~] trust account from which money is to be disbursed contains a sufficient credit balance

consisting of collected and cleared money at the time the check is drawn, executed, or dated, or money is otherwise disbursed.

(b) As used in this Subsection (7), money is considered to be "collected and cleared," and may be disbursed as follows:

(i) cash may be disbursed on the same day the cash is deposited;

(ii) a wire transfer may be disbursed on the same day the wire transfer is deposited;

(iii) the proceeds of one or more of the following financial instruments may be disbursed on the same day the financial instruments are deposited if received from a single party to the real estate transaction and if the aggregate of the financial instruments for the real estate transaction is less than $10,000:

(A) a cashier's check, certified check, or official check that is drawn on an existing account at a federally insured financial institution;

(B) a check drawn on the trust account of a principal broker or associate broker licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the individual title insurance producer or agency title insurance producer has reasonable and prudent grounds to believe sufficient money will be available from the trust account on which the check is drawn at the time of disbursement of proceeds from the individual title insurance producer or agency title insurance producer's [~~escrow~~] trust account;

(C) a personal check not to exceed $500 per closing; or

(D) a check drawn on the [~~escrow~~] trust account of another individual title insurance producer or agency title insurance producer, if the individual title insurance producer or agency title insurance producer in the escrow transaction has reasonable and prudent grounds to believe that sufficient money will be available for withdrawal from the account upon which the check is drawn at the time of disbursement of money from the [~~escrow~~] trust account of the individual title insurance producer or agency title insurance producer in the escrow transaction;

(iv) deposits made through the ACH network may be disbursed on the same day the deposit is made if:

(A) the transferred funds remain uniquely designated and traceable throughout the entire ACH network transfer process;

(B) except as a function of the ACH network process, the transferred funds are not subject to comingling or third party access during the transfer process;

(C) the transferred funds are deposited into the title insurance producer's [~~escrow~~] trust account and are available for disbursement; and

(D) either the ACH network payment type or the title insurance producer's systems prevent the transaction from being unilaterally canceled or reversed by the consumer once the transferred funds are deposited to the individual title insurance producer or agency title producer; or

(v) deposits may be disbursed on the same day the deposit is made if the deposit is made via:

(A) the Federal Reserve Bank through the Federal Reserve's Fedwire funds transfer system; or

(B) a funds transfer system provided by an association of [~~banks~~] federally insured depository institutions.

(c) A check or deposit not described in Subsection (7)(b) may be disbursed:

(i) within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

(ii) upon notification from the financial institution to which the money has been deposited that final settlement has occurred on the deposited financial instrument.

(8) An individual title insurance producer or agency title insurance producer shall maintain a record of a receipt or disbursement of escrow money.

(9) An individual title insurance producer or agency title insurance producer shall comply with:

(a) Section 31A-23a-409;

(b) Title 46, Chapter 1, Notaries Public Reform Act; and

(c) any rules adopted by the Title and Escrow Commission, subject to Section 31A-2-404, that govern escrows.

(10) If an individual title insurance producer or agency title insurance producer conducts a search for real estate located in the state, the individual title insurance producer or agency title insurance producer shall conduct a reasonable search of the public records.

Section 27. Section **31A-23a-413** is amended to read:

31A-23a-413 (Effective 05/01/24). Title insurance producer's annual report.

An agency title insurance producer[~~ and an individual title insurance producer who is not an employee of a title insurer or who has not been designated by an agency title insurance producer~~] shall annually file with the commissioner, by a date and in a form

the commissioner specifies by rule, a verified statement of the agency title insurance producer's [~~or individual title insurance producer's~~]financial condition, transactions, and affairs as of the end of the preceding calendar year.

Section 28. Section **31A-26-301.6** is amended to read:

31A-26-301.6 (Effective 05/01/24). Health care claims practices.

(1) As used in this section:

(a) "Health care provider" means a person licensed to provide health care under:

(i) Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection; or

(ii) Title 58, Occupations and Professions.

(b) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.

(c) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of:

(i) an agreement between the insurer and the provider;

(ii) [~~a~~] an accident and health insurance policy or contract of the insurer; or

(iii) state or federal law.

(2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section.

(3) (a) Except as provided in Subsection (4), within 30 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation for the denial.

(b) (i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a) may be extended by 15 days if the insurer:

(A) determines that the extension is necessary due to matters beyond the control of the insurer; and

(B) before the end of the 30-day period described in Subsection (3)(a), notifies the provider and insured in writing of:

(I) the circumstances requiring the extension of time; and

(II) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(ii) If an extension is necessary due to a failure of the provider or insured to submit the information necessary to decide the claim:

(A) the notice of extension required by this Subsection (3)(b) shall specifically describe the required information; and

(B) the insurer shall give the provider or insured at least 45 days from the day on which the provider or insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (3)(b)(ii)(A).

(4) (a) In the case of a claim for income replacement benefits, within 45 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation of the denial.

(b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a) may be extended for 30 days if the insurer:

(i) determines that the extension is necessary due to matters beyond the control of the insurer; and

(ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies the insured of:

(A) the circumstances requiring the extension of time; and

(B) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(c) Subject to Subsections (4)(d) and (e), the time period for complying with Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the 30-day extension period provided in Subsection (4)(b) ends if before the day on which the 30-day extension period ends, the insurer:

(i) determines that due to matters beyond the control of the insurer a decision cannot be rendered within the 30-day extension period; and

(ii) notifies the insured of:

(A) the circumstances requiring the extension; and

(B) the date as of which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(d) A notice of extension under this Subsection (4) shall specifically explain:

(i) the standards on which entitlement to a benefit is based; and

(ii) the unresolved issues that prevent a decision on the claim.

(e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of the insured to submit the information necessary to decide the claim:

(i) the notice of extension required by Subsection (4)(b) or (c) shall specifically describe the necessary information; and

(ii) the insurer shall give the insured at least 45 days from the day on which the insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (4)(b) or (c).

(5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or (4)(c), due to an insured or provider failing to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the insured or provider until the date on which the insured or provider responds to the request for additional information.

(6) An insurer shall pay all sums to the provider or insured that the insurer is obligated to pay on the claim, and provide a written explanation of the insurer's decision regarding any part of the claim that is denied within 20 days of receiving the information requested under Subsection (3)(b), (4)(b), or (4)(c).

(7) (a) Whenever an insurer makes a payment to a provider on any part of a claim under this section, the insurer shall also send to the insured an explanation of benefits paid.

(b) Whenever an insurer denies any part of a claim under this section, the insurer shall also send to the insured:

(i) a written explanation of the part of the claim that was denied; and

(ii) notice of the adverse benefit determination review process established under Section 31A-22-629.

(c) This Subsection (7) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26B-3-101, unless required by the Department of Health and Human Services or federal law.

(8) (a) A late fee shall be imposed on:

(i) an insurer that fails to timely pay a claim in accordance with this section; and

(ii) a provider that fails to timely provide information on a claim in accordance with this section.

(b) The late fee described in Subsection (8)(a) shall be determined by multiplying together:

(i) the total amount of the claim the insurer is obliged to pay;

(ii) the total number of days the response or the payment is late; and

(iii) 0.033% daily interest rate.

(c) Any late fee paid or collected under this Subsection (8) shall be separately identified on the documentation used by the insurer to pay the claim.

(d) For purposes of this Subsection (8), "late fee" does not include an amount that is less than $1.

(9) Each insurer shall establish a review process to resolve claims-related disputes between the insurer and providers.

(10) An insurer or person representing an insurer may not engage in any unfair claim settlement practice with respect to a provider. Unfair claim settlement practices include:

(a) knowingly misrepresenting a material fact or the contents of an insurance policy in connection with a claim;

(b) failing to acknowledge and substantively respond within 15 days to any written communication from a provider relating to a pending claim;

(c) denying or threatening to deny the payment of a claim for any reason that is not clearly described in the insured's policy;

(d) failing to maintain a payment process sufficient to comply with this section;

(e) failing to maintain claims documentation sufficient to demonstrate compliance with this section;

(f) failing, upon request, to give to the provider written information regarding the specific rate and terms under which the provider will be paid for health care services;

(g) failing to timely pay a valid claim in accordance with this section as a means of influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual relationship;

(h) failing to pay the sum when required and as required under Subsection (8) when a violation has occurred;

(i) threatening to retaliate or actual retaliation against a provider for the provider applying this section;

(j) any material violation of this section; and

(k) any other unfair claim settlement practice established in rule or law.

(11) (a) The provisions of this section shall apply to each contract between an insurer and a provider for the duration of the contract.

(b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad faith insurance claim.

(c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer and a provider from including provisions in their contract that are more stringent than the provisions of this section.

(12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.

(b) The commissioner may adopt rules only as necessary to implement this section.

(c) The commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.

(d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules regarding the review process required by Subsection (9).

(13) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5.

(14) Nothing in this section may be construed as limiting the ability of an insurer to:

(a) recover any amount improperly paid to a provider or an insured:

(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;

(ii) within 24 months of the amount improperly paid for a coordination of benefits error;

(iii) within 12 months of the amount improperly paid for any other reason not identified in Subsection (14)(a)(i) or (ii); or

(iv) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program;

(b) take any action against a provider that is permitted under the terms of the provider contract and not prohibited by this section;

(c) report the provider to a state or federal agency with regulatory authority over the provider for unprofessional, unlawful, or fraudulent conduct; or

(d) enter into a mutual agreement with a provider to resolve alleged violations of this section through mediation or binding arbitration.

(15) A[~~health care~~] provider may only seek recovery from the insurer for an amount improperly paid by the insurer within the same time frames as Subsections (14)(a) and

(b).

(16) (a) An insurer may offer the remittance of payment through a credit card or other similar arrangement.

(b) (i) A[~~health care~~] provider may elect not to receive remittance through a credit card or other similar arrangement.

(ii) An insurer:

(A) shall permit a[~~health care~~] provider's election described in Subsection (16)(b)(i) to apply to the[~~health care~~] provider's entire practice; and

(B) may not require a[~~health care~~] provider's election described in Subsection (16)(b)(i) to be made on a patient-by-patient basis.

(c) An insurer may not require a[~~health care~~] provider or insured to accept remittance through a credit card or other similar arrangement.

Section 29. Section **31A-27a-108.1** is enacted to read:

31A-27a-108.1 (Effective 05/01/24). Injunctions and orders applicable to a federal home loan bank.

(1) As used in this section:

(a) "Federal home loan bank" means the same as that term is defined in 12 U.S.C. Sec. 1422.

(b) "Insurer-member" means an insurer that is a member as defined in 12 U.S.C. Sec. 1422.

(2) (a) Notwithstanding any other provision of this chapter, after the seventh day following the filing of a delinquency proceeding, a state court may not stay or prohibit a federal home loan bank from exercising its rights regarding collateral pledged by an insurer-member.

(b) A federal home loan bank may repurchase any outstanding capital stock that is in excess of the amount of federal home loan bank stock that the federal loan bank requires the insurer-member to hold as a minimum investment if:

(i) the insurer-member is subject to a delinquency proceeding;

(ii) the federal home loan bank exercises the federal home loan bank's rights regarding collateral pledged by the insurer-member;

(iii) the federal home loan bank, in good faith, determines the repurchase is permissible under applicable laws, regulations, regulatory obligations, and the federal home loan bank's capital plan; and

(iv) the repurchase is consistent with the federal home loan bank's current capital

stock practices that apply to the federal home loan bank's entire membership.

(c) Subject to Subsection (2)(d), after a court appoints a receiver for an insurer-member, a federal home loan bank shall provide the receiver a process, and establish a timeline, for the following:

(i) the release of collateral that exceeds the amount required to support secured obligations remaining after any repayment of loans as determined in accordance with the applicable agreements between the federal home loan bank and the insurer-member;

(ii) the release of any of the insurer-member's collateral remaining in the federal home loan bank's possession following full repayment of all outstanding secured obligations of the insurer-member;

(iii) the payment of fees owed by the insurer-member and the operation of deposits and other accounts of the insurer-member with the federal home loan bank; and

(iv) the possible redemption or repurchase of federal home loan bank stock or excess stock of any class that an insurer-member is required to own.

(d) An insurer-member shall provide the information described in Subsection (2)(c) within 10 business days after the day on which the receiver requests the information.

(e) Upon request from a receiver, a federal home loan bank shall provide any available options for an insurer-member subject to a delinquency proceeding to renew or restructure a loan to defer associated prepayment fees, subject to:

(i) market conditions;

(ii) the terms of any loan outstanding to the insurer-member;

(iii) the applicable policies of the federal home loan bank; and

(iv) the federal home loan bank's compliance with federal laws and regulations.

(3) (a) Notwithstanding any other provision of this chapter, the receiver for an insurer-member may not void any transfer of, or any obligation to transfer, money or any other property arising under or in connection with:

(i) any federal home loan bank security agreement;

(ii) any pledge, security, collateral, or guarantee agreement; or

(iii) any other similar arrangement or credit enhancement relating to a federal home loan bank security agreement made in the ordinary course of business and in compliance with the applicable federal home loan bank agreement.

(b) Notwithstanding Subsection (3)(a), an insurer-member may avoid a transfer if a party to the transfer made the transfer with intent to hinder, delay, or defraud the

insurer-member, the receiver for the insurer-member, or an existing or future creditor.

(c) This subsection shall not affect a receiver's rights regarding advances to an insurer-member in a delinquency proceeding pursuant to 12 C.F.R. Sec. 1266.4.

Section 30. Section **31A-28-113** is amended to read:

31A-28-113 (Effective 05/01/24). Credit for assessments paid.

(1) (a) A member insurer may offset against its premium tax, income tax, or franchise tax liability to this state an assessment described in Subsection 31A-28-109(2)(b) to the extent of 20% of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid.

(b) To the extent that the offsets described in Subsection (1)(a) exceed[~~premium~~] tax liability, the offsets may be carried forward and used to offset[~~premium~~] tax liability in future years.

(c) If a member insurer ceases doing business, all uncredited assessments may be credited against its[~~premium~~] tax liability for the year it ceases doing business.

(2) (a) A member insurer that is exempt from taxes described in Subsection (1) may recoup the member insurer's assessment by a surcharge on premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the commissioner.

(b) Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax, income tax, franchise tax, producer commission, or, to the extent allowed under federal law, medical loss ratio.

(c) If a member insurer collects excess surcharges, the member insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

(3) (a) Money shall be paid by the member insurers to the state in a manner required by the State Tax Commission if the money:

(i) is acquired by refund in accordance with Subsection 31A-28-109(6) from the association by member insurers; and

(ii) has been offset against[~~premium~~] taxes as provided in Subsection (1).

(b) The association shall notify the commissioner that the refunds described in Subsection (3)(a) have been made.

Section 31. Section **31A-31-108** is amended to read:

31A-31-108 (Effective 05/01/24). Assessment of insurers.

(1) For purposes of this section:

(a) The commissioner shall by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, define:

(i) "annuity consideration";

(ii) "membership fees";

(iii) "other fees";

(iv) "deposit-type contract funds"; and

(v) "other considerations in Utah."

(b) "Insurance fraud provisions" means:

(i) this chapter;

(ii) Section 34A-2-110; and

(iii) Section 76-6-521.

(c) "Utah consideration" means:

(i) the total premiums written for Utah risks;

(ii) annuity consideration;

(iii) membership fees collected by the insurer;

(iv) other fees collected by the insurer;

(v) deposit-type contract funds; and

(vi) other considerations in Utah.

(d) "Utah risks" means insurance coverage on the lives, health, or against the liability of persons residing in Utah, or on property located in Utah, other than property temporarily in transit through Utah.

(2) To implement insurance fraud provisions, the commissioner may assess an admitted insurer and a nonadmitted insurer transacting insurance under Chapter 15, Part 1, Unauthorized Insurers and Surplus Lines, and Chapter 15, Part 2, Risk Retention Groups Act, an annual fee as follows:

(a) [~~$200~~] $225 for an insurer for which the sum of the Utah consideration is less than or equal to $1,000,000;

(b) [~~$450~~] $525 for an insurer for which the sum of the Utah consideration is greater than $1,000,000 but is less than or equal to $2,500,000;

(c) [~~$800~~] $925 for an insurer for which the sum of the Utah consideration is greater than $2,500,000 but is less than or equal to $5,000,000;

(d) [~~$1,600~~] $1,850 for an insurer for which the sum of the Utah consideration is greater than $5,000,000 but less than or equal to $10,000,000;

(e) [~~$6,100~~] $7,000 for an insurer for which the sum of the Utah consideration is greater

than $10,000,000 but less than $50,000,000; and

(f) [~~$15,000~~] $17,250 for an insurer for which the sum of the Utah consideration equals or exceeds $50,000,000.

(3) Money received by the state under this section shall be deposited into the Insurance Fraud Investigation Restricted Account created in Subsection (4).

(4) (a) There is created in the General Fund a restricted account known as the "Insurance Fraud Investigation Restricted Account."

(b) The Insurance Fraud Investigation Restricted Account shall consist of the money received by the commissioner under this section and Subsections 31A-31-109 (1)(a)(ii), (1)(b), (2)(b)(i), (2)(c), and (3)(a). Money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a) shall be deposited in the Insurance Fraud Victim Restitution Fund pursuant to Section 31A-31-108.5.

(c) The commissioner shall administer the Insurance Fraud Investigation Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Insurance Fraud Investigation Restricted Account to pay for a cost or expense incurred by the commissioner in the administration, investigation, and enforcement of insurance fraud provisions.

Section 32. Section **31A-35-202** is amended to read:

31A-35-202 (Effective 05/01/24). Board responsibilities.

(1) The board shall:

(a) meet:

(i) at least quarterly; and

(ii) at the call of the chair;

(b) make written recommendations to the commissioner for rules governing the following aspects of the bail bond insurance business:

(i) qualifications, applications, and fees for obtaining:

(A) a license required by this Section 31A-35-401; or

(B) a certificate;

(ii) limits on the aggregate amounts of bail bonds;

(iii) unprofessional conduct;

(iv) procedures for hearing and resolving allegations of unprofessional conduct; and

(v) sanctions for unprofessional conduct;

(c) screen:

(i) bail bond agency license applications; and

(ii) persons applying for a bail bond agency license; and

(d) recommend to the commissioner action regarding the granting, [~~renewing, ~~] suspending, revoking, and reinstating of bail bond agency license.

(2) Nothing in Subsection (1)(d) precludes the commissioner from suspending a license under Section 31A-35-504.

[~~(2)~~] (3) The board may:

(a) conduct investigations of allegations of unprofessional conduct on the part of persons or bail bond agencies involved in the business of bail bond insurance; and

(b) provide the results of the investigations described in Subsection [~~(2)(a)~~] (3)(a) to the commissioner with recommendations for:

(i) action; and

(ii) any appropriate sanctions.

Section 33. Section **31A-35-406** is amended to read:

31A-35-406 (Effective 05/01/24). Initial licensing, license renewal, and license reinstatement.

(1) An applicant for an initial bail bond agency license shall:

(a) complete and submit to the department an application;

(b) submit to the department, as applicable, a copy of the applicant's:

(i) irrevocable letter of credit, as required under Subsection 31A-35-404(1);

(ii) verified financial statement, as required under Subsection 31A-35-404(2); or

(iii) qualifying power of attorney, as required under Subsection 31A-35-404(3); and

(c) pay the department the applicable renewal fee established in accordance with Section 31A-3-103.

(2) (a) A license under this chapter expires annually effective at midnight on August [~~14~~] 31.

(b) To renew a bail bond agency license issued under this chapter, on or before [~~July 15~~] August 31, the bail bond agency shall:

(i) complete and submit to the department a renewal application that includes certification that:

(A) a principal of the agency attended or participated by telephone in at least one entire board meeting during the 12-month period before [~~July 15~~] August 31; and

(B) as of May 1, the agency complies with aggregate bond limits established by rule made in accordance with Title 63G, Chapter 3, Utah Administrative

Rulemaking Act;

(ii) submit to the department, as applicable, a copy of the applicant's:

(A) irrevocable letter of credit, as required under Subsection 31A-35-404(1);

(B) verified financial statement, as required under Subsection 31A-35-404(2); or

(C) qualifying power of attorney, as required under Subsection 31A-35-404(3); and

(iii) pay the department the applicable renewal fee established in accordance with Section 31A-3-103.

(c) A bail bond agency shall renew the bail bond agency's license under this chapter annually as established by department rule, regardless of when the license is issued.

(3) (a) A bail bond agency may apply for reinstatement of an expired bail bond agency license within one year after the day on which the license expires by complying with the renewal requirements described in Subsection (2).

(b) If a bail bond agency license has been expired for more than one year, the person applying for reinstatement of the bail bond agency license shall comply with the initial licensing requirements described in Subsection (1).

(4) If a bail bond agency license is suspended, the applicant may not submit an application for a bail bond agency license until after the day on which the period of suspension ends.

(5) The department shall deposit a fee collected under this section in the restricted account created in Section 31A-35-407.

Section 34. Section **31A-37-202** is amended to read:

31A-37-202 (Effective 05/01/24). Permissive areas of insurance.

(1) Except as provided in Subsections (2) and (3), a captive insurance company may not directly insure a risk other than the risk of the captive insurance company's parent or affiliated company.

(2) In addition to the risks described in Subsection (1), an association captive insurance company may insure the risk of:

(a) a member organization of the association captive insurance company's association; or

(b) an affiliate of a member organization of the association captive insurance company's association.

(3) The following may insure a risk of a controlled unaffiliated business:

(a) an industrial insured captive insurance company;

(b) a protected cell;

(c) a pure captive insurance company; or

(d) a sponsored captive insurance company.

(4) To the extent allowed by a captive insurance company's organizational charter, a captive insurance company may provide any type of insurance described in this title, except:

(a) workers' compensation insurance;

(b) personal motor vehicle insurance;

(c) homeowners' insurance; and

(d) any component of the types of insurance described in Subsections (4)(a) through (c).

(5) A captive insurance company may not provide coverage for:

(a) a wager or gaming risk;

(b) loss of an election; or

(c) the penal consequences of a crime.

(6) Unless the punitive damages award arises out of a criminal act of an insured, a captive insurance company may provide coverage for punitive damages awarded, including through adjudication or compromise, against the captive insurance company's:

(a) parent; or

(b) affiliated company.

(7) Notwithstanding Subsection (4), if approved by the commissioner[~~,~~] :

(a) a captive insurance company may insure as a reimbursement a limited layer or deductible of workers' compensation coverage[~~.~~] ; and

(b) an association captive insurance company that satisfies the requirements of this chapter may provide homeowners' insurance.

Section 35. Section **31A-37-204** is amended to read:

31A-37-204 (Effective 05/01/24). Paid-in capital -- Other capital.

(1) (a) The commissioner may not issue a certificate of authority to a company described in Subsection (1)(c) unless the company possesses and thereafter maintains unimpaired paid-in capital and unimpaired paid-in surplus of:

(i) in the case of a pure captive insurance company:

(A) except as provided in Subsection (1)(a)(i)(B), not less than $250,000; or

(B) if the pure captive insurance company is not acting as a pool that facilitates risk distribution for other captive insurers, an amount that is the greater of:

(I) not less than 20% of the company's total aggregate risk; or

(II) $50,000;

(ii) in the case of an association captive insurance company, not less than $750,000;

(iii) in the case of an industrial insured captive insurance company incorporated as a

stock insurer, not less than $700,000;

(iv) in the case of a sponsored captive insurance company, not less than [~~$500,000,~~] $250,000 of which a minimum of [~~$200,000~~] $50,000 is provided by the sponsor; or

(v) in the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro-formas, including the nature of the risks to be insured.

(b) The paid-in capital and surplus required under this Subsection (1) may be in the form of:

(i) (A) cash; or

(B) cash equivalent;

(ii) an irrevocable letter of credit:

(A) issued by:

(I) a bank chartered by this state;

(II) a member bank of the Federal Reserve System; or

(III) a member bank of the Federal Deposit Insurance Corporation;

(B) approved by the commissioner;

(iii) marketable securities as determined by Subsection (5); or

(iv) some other thing of value approved by the commissioner, for a period not to exceed 45 days, to facilitate the formation of a captive insurance company in this state pursuant to an approved plan of liquidation and reorganization of another captive insurance company or alien captive insurance company in another jurisdiction.

(c) This Subsection (1) applies to:

(i) a pure captive insurance company;

(ii) a sponsored captive insurance company;

(iii) a special purpose captive insurance company;

(iv) an association captive insurance company; or

(v) an industrial insured captive insurance company.

(2) (a) The commissioner may, under Section 31A-37-106, prescribe additional capital based on the type, volume, and nature of insurance business transacted.

(b) The capital prescribed by the commissioner under this Subsection (2) may be in the form of:

(i) cash;

(ii) an irrevocable letter of credit issued by:

(A) a bank chartered by this state; or

(B) a member bank of the Federal Reserve System; or

(iii) marketable securities as determined by Subsection (5).

(3) (a) Except as provided in Subsection (3)(c), a branch captive insurance company, as security for the payment of liabilities attributable to branch operations, shall, through its branch operations, establish and maintain a trust fund:

(i) funded by an irrevocable letter of credit or other acceptable asset; and

(ii) in the United States for the benefit of:

(A) United States policyholders; and

(B) United States ceding insurers under:

(I) insurance policies issued; or

(II) reinsurance contracts issued or assumed.

(b) The amount of the security required under this Subsection (3) shall be no less than:

(i) the capital and surplus required by this chapter; and

(ii) the reserves on the insurance policies or reinsurance contracts, including:

(A) reserves for losses;

(B) allocated loss adjustment expenses;

(C) incurred but not reported losses; and

(D) unearned premiums with regard to business written through branch operations.

(c) Notwithstanding the other provisions of this Subsection (3):

(i) the commissioner may permit a branch captive insurance company that is required to post security for loss reserves on branch business by its reinsurer to reduce the funds in the trust account required by this section by the same amount as the security posted if the security remains posted with the reinsurer; and

(ii) a branch captive insurance company that is the result of the licensure of an alien captive insurance company that is not formed in an alien jurisdiction is not subject to the requirements of this Subsection (3).

(4) (a) A captive insurance company may not pay the following without the prior approval of the commissioner:

(i) a dividend out of capital or surplus in excess of the limits under Section 16-10a-640; or

(ii) a distribution with respect to capital or surplus in excess of the limits under

Section 16-10a-640.

(b) The commissioner shall condition approval of an ongoing plan for the payment of dividends or other distributions on the retention, at the time of each payment, of capital or surplus in excess of:

(i) amounts specified by the commissioner under Section 31A-37-106; or

(ii) determined in accordance with formulas approved by the commissioner under Section 31A-37-106.

(5) For purposes of this section, marketable securities means:

(a) a bond or other evidence of indebtedness of a governmental unit in the United States or Canada or any instrumentality of the United States or Canada; or

(b) securities:

(i) traded on one or more of the following exchanges in the United States:

(A) New York;

(B) American; or

(C) NASDAQ;

(ii) when no particular security, or a substantially related security, applied toward the required minimum capital and surplus requirement of Subsection (1) represents more than 50% of the minimum capital and surplus requirement; and

(iii) when no group of up to four particular securities, consolidating substantially related securities, applied toward the required minimum capital and surplus requirement of Subsection (1) represents more than 90% of the minimum capital and surplus requirement.

(6) Notwithstanding Subsection (5), to protect the solvency and liquidity of a captive insurance company, the commissioner may reject the application of specific assets or amounts of specific assets to satisfying the requirement of Subsection (1).

Section 36. Section **31A-37-502** is amended to read:

31A-37-502 (Effective 05/01/24). Examination.

(1) (a) As provided in this section, the commissioner, or a person appointed by the commissioner, [~~shall~~] may examine each captive insurance company [~~in each five-year period.~~] at least once every five years, or more frequently if the commissioner determines a more frequent examination is prudent.

(b) The five-year period described in Subsection (1)(a) shall be determined on the basis of five full annual accounting periods of operation.

(c) The examination is to be made as of:

(i) December 31 of the full five-year period; or

(ii) the last day of the month of an annual accounting period authorized for a captive insurance company under this section.

[~~(d) In addition to an examination required under this Subsection (1), the commissioner, or a person appointed by the commissioner may examine a captive insurance company whenever the commissioner determines it to be prudent.~~]

(2) During an examination under this section the commissioner, or a person appointed by the commissioner, shall thoroughly inspect and examine the affairs of the captive insurance company to ascertain all or any combination of the following:

(a) the financial condition of the captive insurance company;

(b) the ability of the captive insurance company to fulfill the insurance policy obligations of the captive insurance company; and

(c) whether the captive insurance company has complied with this chapter.

[~~(3) The commissioner may accept a comprehensive annual independent audit in lieu of an examination:~~]

[~~(a) of a scope satisfactory to the commissioner; and~~]

[~~(b) performed by an independent auditor approved by the commissioner.~~]

[~~(4)~~] (3) A captive insurance company that is inspected and examined under this section shall pay, as provided in Subsection 31A-37-201(6)(b), the expenses and charges of an inspection and examination.

Section 37. **Repealer.**

This bill repeals:

Section **31A-2-303, (Effective 05/01/24)Notice.**

Section 38. **FY 2025 Appropriation.**

The following sums of money are appropriated for the fiscal year beginning July 1, 2024, and ending June 30, 2025. These are additions to amounts previously appropriated for fiscal year 2025.

Subsection 38(a) **Restricted Fund and Account Transfers**

The Legislature authorizes the State Division of Finance to transfer the following amounts between the following funds or accounts as indicated. Expenditures and outlays from the funds to which the money is transferred must be authorized by an appropriation.

ITEM 1 To Insurance Department Administration

From General Fund Restricted - Relative Value Study Account, One-time $400,000

Schedule of Programs:

Administration $400,000

The Legislature intends that the appropriation under this item be used for the study described in Section 31A-2-218.1.

Section 39. **Effective date.**

(1) Except as provided in Subsections (2) and (3), this bill takes effect on May 1, 2024.

(2) (a) Except as provided in Subsection (2)(b), the actions affecting Section 31A-2-218.1 take effect upon approval by the governor, or the day following the constitutional time limit of Utah Constitution, Article VII, Section 8, without the governor's signature, or in the case of a veto, the date of veto override.

(b) If this bill is not approved by two-thirds of all members elected to each house, the actions affecting Section 31A-2-218.1 take effect on May 1, 2024.

(3) The actions affecting Section 31A-22-614 take effect on July 1, 2024.