

**Senator Thomas V. Hatch** proposes the following substitute bill:

**INSURANCE LAW REVISIONS**

2004 GENERAL SESSION

STATE OF UTAH

**Sponsor: James A. Ferrin**

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**LONG TITLE**

**General Description:**

This bill modifies the Insurance Code.

**Highlighted Provisions:**

This bill:

- ▶ modifies definition provisions;
- ▶ addresses examination costs;
- ▶ addresses confidentiality and distribution of certain records or documents;
- ▶ corrects cross references;
- ▶ addresses extension of the deadline for filing fee payments for annual statements;
- ▶ addresses use of technical experts in evaluating mergers and acquisitions;
- ▶ prohibits certain activities related to Social Security numbers;
- ▶ addresses the deposit of funds by a licensee;
- ▶ modifies trust obligations for funds collected;
- ▶ addresses grounds for probation;
- ▶ modifies trust obligations for funds collected;
- ▶ modifies the Comprehensive Health Insurance Pool Act including:
  - defining terms;
  - expanding the board;
  - addressing eligibility;



- 26 • addressing preexisting conditions;
- 27 • addressing deductibles and copayments; and
- 28 • repealing employee contribution provisions;
- 29 ▶ enacts the Federal Health Care Tax Credit Program Act; § [and]
- 29a ▶ **PROVIDES A REPEAL DATE FOR THE FEDERAL HEALTH CARE TAX CREDIT PROGRAM ACT;**
- 29b **AND §**
- 30 ▶ makes technical changes.

31 **Monies Appropriated in this Bill:**

32 None

33 **Other Special Clauses:**

34 This bill provides an effective date.

35 This bill provides revisor instructions.

36 **Utah Code Sections Affected:**

37 **AMENDS:**

- 38 **31A-1-301**, as last amended by Chapters 131 and 298, Laws of Utah 2003
- 39 **31A-2-205**, as last amended by Chapter 298, Laws of Utah 2003
- 40 **31A-2-207**, as last amended by Chapter 259, Laws of Utah 1991
- 41 **31A-2-309**, as last amended by Chapter 298, Laws of Utah 2003
- 42 **31A-4-113**, as last amended by Chapter 116, Laws of Utah 2001
- 43 **31A-8-103**, as last amended by Chapter 298, Laws of Utah 2003
- 44 **31A-16-103**, as last amended by Chapter 1, Laws of Utah 2000
- 45 **31A-23a-112**, as renumbered and amended by Chapter 298, Laws of Utah 2003
- 46 **31A-23a-409**, as renumbered and amended by Chapter 298, Laws of Utah 2003
- 47 **31A-29-103**, as last amended by Chapter 168, Laws of Utah 2003
- 48 **31A-29-104**, as last amended by Chapter 168, Laws of Utah 2003
- 49 **31A-29-111**, as last amended by Chapter 168, Laws of Utah 2003
- 50 **31A-29-112**, as last amended by Chapter 168, Laws of Utah 2003
- 51 **31A-29-113**, as last amended by Chapter 168, Laws of Utah 2003
- 52 **31A-29-114**, as last amended by Chapter 168, Laws of Utah 2003
- 53 **31A-29-115**, as last amended by Chapter 168, Laws of Utah 2003
- 54 **31A-30-103**, as last amended by Chapters 114 and 308, Laws of Utah 2002
- 55 **31A-30-108**, as last amended by Chapter 308, Laws of Utah 2002
- 56 **63-55b-131**, as last amended by Chapter 298, Laws of Utah 2003

57 ENACTS:

58 **31A-21-110**, Utah Code Annotated 1953

59 **31A-38-101**, Utah Code Annotated 1953

60 **31A-38-102**, Utah Code Annotated 1953

61 **31A-38-103**, Utah Code Annotated 1953

62 **31A-38-104**, Utah Code Annotated 1953

63 REPEALS:

64 **31A-29-118**, as enacted by Chapter 232, Laws of Utah 1990



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

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

68 **31A-1-301. Definitions.**

69 As used in this title, unless otherwise specified:

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

72 (i) a medical condition including:

73 (A) medical care expenses; or

74 (B) the risk of disability;

75 (ii) accident; or

76 (iii) sickness.

77 (b) "Accident and health insurance":

78 (i) includes a contract with disability contingencies including:

79 (A) an income replacement contract;

80 (B) a health care contract;

81 (C) an expense reimbursement contract;

82 (D) a credit accident and health contract;

83 (E) a continuing care contract; and

84 (F) a long-term care [contracts] contract; and

85 (ii) may provide:

86 (A) hospital coverage;

87 (B) surgical coverage;

88 (C) medical coverage; or

89 (D) loss of income coverage.

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

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

92 63, Chapter 46a, Utah Administrative Rulemaking Act.

93 (3) "Administrator" is defined in Subsection [~~(149)~~] (150).

94 (4) "Adult" means a natural person who has attained the age of at least 18 years.

95 (5) "Affiliate" means any person who controls, is controlled by, or is under common  
96 control with, another person. A corporation is an affiliate of another corporation, regardless of  
97 ownership, if substantially the same group of natural persons manages the corporations.

98 (6) "Agency" means:

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

101 (b) an insurance organization licensed or required to be licensed under Section  
102 31A-23a-301.

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

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

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

109 (10) "Application" means a document:

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

111 and

112 [~~(b)~~] (ii) that contains information that is used by the insurer to[~~:(i)~~] evaluate risk[;]

113 and [~~(ii)~~] decide whether to:

114 (A) insure the risk under:

115 (I) the coverages as originally offered; or

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

117 (B) decline to insure the risk[;]; or

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

119 annuity contract.

120 (11) "Articles" or "articles of incorporation" means the original articles, special laws,  
121 charters, amendments, restated articles, articles of merger or consolidation, trust instruments,  
122 and other constitutive documents for trusts and other entities that are not corporations, and  
123 amendments to any of these.

124 (12) "Bail bond insurance" means a guarantee that a person will attend court when  
125 required, or will obey the orders or judgment of the court, as a condition to the release of that  
126 person from confinement.

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

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

130 (15) "Business entity" means a corporation, association, partnership, limited liability  
131 company, limited liability partnership, or other legal entity.

132 (16) "Business of insurance" is defined in Subsection [~~(80)~~] (81).

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

136 (a) Section 31A-7-201;

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

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

139 (18) "Bylaws" means the rules adopted for the regulation or management of a  
140 corporation's affairs, however designated and includes comparable rules for trusts and other  
141 entities that are not corporations.

142 (19) "Captive insurance company" means:

143 (a) an insurance company:

144 (i) owned by another organization; and

145 (ii) whose exclusive purpose is to insure risks of the parent organization and affiliated  
146 companies; or

147 (b) in the case of groups and associations, an insurance organization:

148 (i) owned by the insureds; and

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

- 150 (A) member organizations;
- 151 (B) group members; and
- 152 (C) affiliates of:
  - 153 (I) member organizations; or
  - 154 (II) group members.
- 155 (20) "Casualty insurance" means liability insurance as defined in Subsection [~~(90)~~
- 156 (91).
- 157 (21) "Certificate" means evidence of insurance given to:
  - 158 (a) an insured under a group insurance policy; or
  - 159 (b) a third party.
- 160 (22) "Certificate of authority" is included within the term "license."
- 161 (23) "Claim," unless the context otherwise requires, means a request or demand on an
- 162 insurer for payment of benefits according to the terms of an insurance policy.
- 163 (24) "Claims-made coverage" means an insurance contract or provision limiting
- 164 coverage under a policy insuring against legal liability to claims that are first made against the
- 165 insured while the policy is in force.
- 166 (25) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
- 167 commissioner.
- 168 (b) When appropriate, the terms listed in Subsection (25)(a) apply to the equivalent
- 169 supervisory official of another jurisdiction.
- 170 (26) (a) "Continuing care insurance" means insurance that:
  - 171 (i) provides board and lodging;
  - 172 (ii) provides one or more of the following services:
    - 173 (A) personal services;
    - 174 (B) nursing services;
    - 175 (C) medical services; or
    - 176 (D) other health-related services; and
  - 177 (iii) provides the coverage described in Subsection (26)(a)(i) under an agreement
  - 178 effective:
    - 179 (A) for the life of the insured; or
    - 180 (B) for a period in excess of one year.

181 (b) Insurance is continuing care insurance regardless of whether or not the board and  
182 lodging are provided at the same location as the services described in Subsection (26)(a)(ii).

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

- 186 (i) by contract;
- 187 (ii) by common management;
- 188 (iii) through the ownership of voting securities; or
- 189 (iv) by a means other than those described in Subsections (27)(a)(i) through (iii).

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

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

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

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

199 (29) "Controlling person" means any person~~[- firm, association, or corporation]~~ that  
200 directly or indirectly has the power to direct or cause to be directed, the management, control,  
201 or activities of a reinsurance intermediary.

202 (30) "Controlling producer" means a producer who directly or indirectly controls an  
203 insurer.

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

- 205 (i) a corporation doing business;
  - 206 (A) as:
    - 207 (I) an insurance producer~~[-];~~;
    - 208 (II) a limited line producer~~[-];~~;
    - 209 (III) a consultant~~[-];~~;
    - 210 (IV) a managing general agent~~[-];~~;
    - 211 (V) a reinsurance intermediary~~[-];~~;

212            (VI) a third party administrator[;]; or  
213            (VII) an adjuster; and  
214            (B) under:  
215            [~~(A)~~] (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and  
216 Reinsurance Intermediaries;  
217            [~~(B)~~] (II) Chapter 25, Third Party Administrators; [~~and~~] or  
218            [~~(C)~~] (III) Chapter 26, Insurance Adjusters; or  
219            (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance  
220 Holding Companies.  
221            (b) "Stock corporation" means a stock insurance corporation.  
222            (c) "Mutual" or "mutual corporation" means a mutual insurance corporation.  
223            (32) "Credit accident and health insurance" means insurance on a debtor to provide  
224 indemnity for payments coming due on a specific loan or other credit transaction while the  
225 debtor is disabled.  
226            (33) (a) "Credit insurance" means insurance offered in connection with an extension of  
227 credit that is limited to partially or wholly extinguishing that credit obligation.  
228            (b) "Credit insurance" includes:  
229            (i) credit accident and health insurance;  
230            (ii) credit life insurance;  
231            (iii) credit property insurance;  
232            (iv) credit unemployment insurance;  
233            (v) guaranteed automobile protection insurance;  
234            (vi) involuntary unemployment insurance;  
235            (vii) mortgage accident and health insurance;  
236            (viii) mortgage guaranty insurance; and  
237            (ix) mortgage life insurance.  
238            (34) "Credit life insurance" means insurance on the life of a debtor in connection with  
239 an extension of credit that pays a person if the debtor dies.  
240            (35) "Credit property insurance" means insurance:  
241            (a) offered in connection with an extension of credit; and  
242            (b) that protects the property until the debt is paid.

- 243 (36) "Credit unemployment insurance" means insurance:  
244 (a) offered in connection with an extension of credit; and  
245 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:  
246 (i) specific loan; or  
247 (ii) credit transaction.
- 248 (37) "Creditable coverage" is as defined in 45 C.F.R. 146.113(a).
- 249 (38) "Creditor" means a person, including an insured, having any claim, whether:  
250 (a) matured;  
251 (b) unmatured;  
252 (c) liquidated;  
253 (d) unliquidated;  
254 (e) secured;  
255 (f) unsecured;  
256 (g) absolute;  
257 (h) fixed; or  
258 (i) contingent.
- 259 (39) (a) "Customer service representative" means a person that provides insurance  
260 services and insurance product information:  
261 (i) for the customer service representative's;  
262 (A) producer; or  
263 (B) consultant employer; and  
264 (ii) to the customer service representative's employer's;  
265 (A) customer[;];  
266 (B) client[;]; or  
267 (C) organization.
- 268 (b) A customer service representative may only operate within the scope of authority of  
269 the customer service representative's producer or consultant employer.
- 270 (40) "Deadline" means the final date or time:  
271 (a) imposed by:  
272 (i) statute;  
273 (ii) rule; or

- 274 (iii) order; and
- 275 (b) by which a required filing or payment must be received by the department.
- 276 (41) "Deemer clause" means a provision under this title under which upon the
- 277 occurrence of a condition precedent, the commissioner is deemed to have taken a specific
- 278 action. If the statute so provides, the condition precedent may be the commissioner's failure to
- 279 take a specific action.
- 280 (42) "Degree of relationship" means the number of steps between two persons
- 281 determined by counting the generations separating one person from a common ancestor and
- 282 then counting the generations to the other person.
- 283 (43) "Department" means the Insurance Department.
- 284 (44) "Director" means a member of the board of directors of a corporation.
- 285 (45) "Disability" means a physiological or psychological condition that partially or
- 286 totally limits an individual's ability to:
- 287 (a) perform the duties of:
- 288 (i) that individual's occupation; or
- 289 (ii) any occupation for which the individual is reasonably suited by education, training,
- 290 or experience; or
- 291 (b) perform two or more of the following basic activities of daily living:
- 292 (i) eating;
- 293 (ii) toileting;
- 294 (iii) transferring;
- 295 (iv) bathing; or
- 296 (v) dressing.
- 297 (46) "Disability income insurance" is defined in Subsection [~~(71)~~] (72).
- 298 (47) "Domestic insurer" means an insurer organized under the laws of this state.
- 299 (48) "Domiciliary state" means the state in which an insurer:
- 300 (a) is incorporated;
- 301 (b) is organized; or
- 302 (c) in the case of an alien insurer, enters into the United States.
- 303 (49) (a) "Eligible employee" means:
- 304 (i) an employee who:

- 305 (A) works on a full-time basis; and
- 306 (B) has a normal work week of 30 or more hours; or
- 307 (ii) a person described in Subsection (49)(b).
- 308 (b) "Eligible employee" includes, if the individual is included under a health benefit
- 309 plan of a small employer:
  - 310 (i) a sole proprietor;
  - 311 (ii) a partner in a partnership; or
  - 312 (iii) an independent contractor.
- 313 (c) "Eligible employee" does not include, unless eligible under Subsection (49)(b):
- 314 (i) an individual who works on a temporary or substitute basis for a small employer;
- 315 (ii) an employer's spouse; or
- 316 (iii) a dependent of an employer.
- 317 (50) "Employee" means any individual employed by an employer.
- 318 (51) "Employee benefits" means one or more benefits or services provided to:
  - 319 (a) employees; or
  - 320 (b) dependents of employees.
- 321 (52) (a) "Employee welfare fund" means a fund:
  - 322 (i) established or maintained, whether directly or through trustees, by:
    - 323 (A) one or more employers;
    - 324 (B) one or more labor organizations; or
    - 325 (C) a combination of employers and labor organizations; and
  - 326 (ii) that provides employee benefits paid or contracted to be paid, other than income
  - 327 from investments of the fund, by or on behalf of an employer doing business in this state or for
  - 328 the benefit of any person employed in this state.
- 329 (b) "Employee welfare fund" includes a plan funded or subsidized by user fees or tax
- 330 revenues.
- 331 (53) "Endorsement" means a written agreement attached to a policy or certificate to
- 332 modify one or more of the provisions of the policy or certificate.
- 333 (54) (a) "Escrow" means:
  - 334 (i) a real estate settlement or real estate closing conducted by a third party pursuant to
  - 335 the requirements of a written agreement between the parties in a real estate transaction; or

336 (ii) a settlement or closing involving:

337 (A) a mobile home;

338 (B) a grazing right;

339 (C) a water right; or

340 (D) other personal property authorized by the commissioner.

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

342 (i) real estate settlement; or

343 (ii) real estate closing.

344 (55) "Escrow agent" means:

345 (a) an insurance producer with:

346 (i) a title insurance line of authority; and

347 (ii) an escrow subline of authority; or

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

349 [~~55~~] (56) "Excludes" is not exhaustive and does not mean that other things are not  
350 also excluded. The items listed are representative examples for use in interpretation of this  
351 title.

352 [~~56~~] (57) "Expense reimbursement insurance" means insurance:

353 (a) written to provide payments for expenses relating to hospital confinements resulting  
354 from illness or injury; and

355 (b) written:

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

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

358 [~~57~~] (58) "Fidelity insurance" means insurance guaranteeing the fidelity of persons  
359 holding positions of public or private trust.

360 [~~58~~] (59) (a) "Filed" means that a filing is:

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

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

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

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

367 (B) rule.

368 (b) "Filed" does not include a filing that is rejected by the department because it is not  
369 submitted in accordance with Subsection [~~(58)~~] (59)(a).

370 [~~(59)~~] (60) "Filing," when used as a noun, means an item required to be filed with the  
371 department including:

372 (a) a policy;

373 (b) a rate;

374 (c) a form;

375 (d) a document;

376 (e) a plan;

377 (f) a manual;

378 (g) an application;

379 (h) a report;

380 (i) a certificate;

381 (j) an endorsement;

382 (k) an actuarial certification;

383 (l) a licensee annual statement;

384 (m) a licensee renewal application; or

385 (n) an advertisement.

386 [~~(60)~~] (61) "First party insurance" means an insurance policy or contract in which the  
387 insurer agrees to pay claims submitted to it by the insured for the insured's losses.

388 [~~(61)~~] (62) "Foreign insurer" means an insurer domiciled outside of this state, including  
389 an alien insurer.

390 [~~(62)~~] (63) (a) "Form" means one of the following prepared for general use:

391 (i) a policy;

392 (ii) a certificate;

393 (iii) an application; or

394 (iv) an outline of coverage.

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

397 [~~(63)~~] (64) "Franchise insurance" means individual insurance policies provided through

398 a mass marketing arrangement involving a defined class of persons related in some way other  
399 than through the purchase of insurance.

400 [~~(64)~~] (65) "General lines of authority" include:

401 (a) the general lines of insurance in Subsection [~~(65)~~] (66);

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

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

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

405 (iii) search and escrow, including authority to act as a title marketing representative;

406 and

407 (iv) title marketing representative only;

408 (c) surplus lines;

409 (d) workers' compensation; and

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

412 [~~(65)~~] (66) "General lines of insurance" include:

413 (a) accident and health;

414 (b) casualty;

415 (c) life;

416 (d) personal lines;

417 (e) property; and

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

419 [~~(66)~~] (67) "Group health plan" means an employee welfare benefit plan to the extent  
420 that the plan provides medical care:

421 (a) (i) to employees; or

422 (ii) to a dependent of an employee; and

423 (b) (i) directly;

424 (ii) through insurance reimbursement; or

425 (iii) through any other method.

426 [~~(67)~~] (68) "Guaranteed automobile protection insurance" means insurance offered in  
427 connection with an extension of credit that pays the difference in amount between the  
428 insurance settlement and the balance of the loan if the insured automobile is a total loss.

429           ~~[(68) "Health]~~ (69) (a) Except as provided in Subsection (69)(b), "health benefit plan"  
430 means a policy or certificate ~~[for]~~ that:  
431           (i) provides health care insurance~~[, except that health benefit plan does not include~~  
432 ~~coverage:]~~;  
433           (ii) provides major medical expense insurance; or  
434           (iii) is offered as a substitute for hospital or medical expense insurance such as:  
435           (A) a hospital confinement indemnity; or  
436           (B) a limited benefit plan.  
437           (b) "Health benefit plan" does not include a policy or certificate that:  
438           ~~[(a)]~~ (i) provides benefits solely for:  
439           ~~[(i)]~~ (A) accident;  
440           ~~[(ii)]~~ (B) dental;  
441           (C) income replacement;  
442           (D) long-term care;  
443           (E) a Medicare supplement;  
444           (F) a specified disease;  
445           ~~[(iii)]~~ (G) vision; or  
446           ~~[(iv) Medicare supplement;]~~  
447           ~~[(v) long-term care; or]~~  
448           ~~[(vi) income replacement; or]~~  
449           ~~[(b) that is:]~~  
450           (H) a short-term limited duration; or  
451           ~~[(i)]~~ (ii) is offered and marketed as supplemental health insurance[;].  
452           ~~[(ii) not offered or marketed as a substitute for:]~~  
453           ~~[(A) hospital or medical expense insurance; or]~~  
454           ~~[(B) major medical expense insurance; and]~~  
455           ~~[(iii) solely for:]~~  
456           ~~[(A) a specified disease;]~~  
457           ~~[(B) hospital confinement indemnity; or]~~  
458           ~~[(C) limited benefit plan:]~~  
459           ~~[(69)]~~ (70) "Health care" means any of the following intended for use in the diagnosis,

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

461 (a) professional services;

462 (b) personal services;

463 (c) facilities;

464 (d) equipment;

465 (e) devices;

466 (f) supplies; or

467 (g) medicine.

468 [~~70~~] (71) (a) "Health care insurance" or "health insurance" means insurance

469 providing:

470 (i) health care benefits; or

471 (ii) payment of incurred health care expenses.

472 (b) "Health care insurance" or "health insurance" does not include accident and health  
473 insurance providing benefits for:

474 (i) replacement of income;

475 (ii) short-term accident;

476 (iii) fixed indemnity;

477 (iv) credit accident and health;

478 (v) supplements to liability;

479 (vi) workers' compensation;

480 (vii) automobile medical payment;

481 (viii) no-fault automobile;

482 (ix) equivalent self-insurance; or

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

485 [~~71~~] (72) "Income replacement insurance" or "disability income insurance" means  
486 insurance written to provide payments to replace income lost from accident or sickness.

487 [~~72~~] (73) "Indemnity" means the payment of an amount to offset all or part of an  
488 insured loss.

489 [~~73~~] (74) "Independent adjuster" means an insurance adjuster required to be licensed  
490 under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.

491           ~~[(74)]~~ (75) "Independently procured insurance" means insurance procured under  
492 Section 31A-15-104.

493           ~~[(75)]~~ (76) "Individual" means a natural person.

494           ~~[(76)]~~ (77) "Inland marine insurance" includes insurance covering:

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

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

497           (c) bailee liability;

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

500           (e) personal and commercial property floaters.

501           ~~[(77)]~~ (78) "Insolvency" means that:

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

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

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

506           ~~[(78)]~~ (79) (a) "Insurance" means:

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

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

511           (b) "Insurance" includes:

512           (i) risk distributing arrangements providing for compensation or replacement for  
513 damages or loss through the provision of services or benefits in kind;

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

516           (iii) plans in which the risk does not rest upon the person who makes the arrangements,  
517 but with a class of persons who have agreed to share it.

518           ~~[(79)]~~ (80) "Insurance adjuster" means a person who directs the investigation,  
519 negotiation, or settlement of a claim under an insurance policy other than life insurance or an  
520 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

521           ~~[(80)]~~ (81) "Insurance business" or "business of insurance" includes:

- 522 (a) providing health care insurance, as defined in Subsection [~~(70)~~] (71), by  
523 organizations that are or should be licensed under this title;
- 524 (b) providing benefits to employees in the event of contingencies not within the control  
525 of the employees, in which the employees are entitled to the benefits as a right, which benefits  
526 may be provided either:
- 527 (i) by single employers or by multiple employer groups; or  
528 (ii) through trusts, associations, or other entities;
- 529 (c) providing annuities, including those issued in return for gifts, except those provided  
530 by persons specified in Subsections 31A-22-1305(2) and (3);
- 531 (d) providing the characteristic services of motor clubs as outlined in Subsection  
532 [~~(106)~~] (107);
- 533 (e) providing other persons with insurance as defined in Subsection [~~(78)~~] (79);
- 534 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,  
535 or surety, any contract or policy of title insurance;
- 536 (g) transacting or proposing to transact any phase of title insurance, including:
- 537 (i) solicitation[;];  
538 (ii) negotiation preliminary to execution[;];  
539 (iii) execution of a contract of title insurance[;];  
540 (iv) insuring[;]; and  
541 (v) transacting matters subsequent to the execution of the contract and arising out of  
542 [~~it~~] the contract, including reinsurance; and
- 543 (h) doing, or proposing to do, any business in substance equivalent to Subsections  
544 [~~(80)~~] (81)(a) through (g) in a manner designed to evade the provisions of this title.
- 545 [~~(81)~~] (82) "Insurance consultant" or "consultant" means a person who:
- 546 (a) advises other persons about insurance needs and coverages;  
547 (b) is compensated by the person advised on a basis not directly related to the insurance  
548 placed; and
- 549 (c) except as provided in Section 31A-23a-501, is not compensated directly or  
550 indirectly by an insurer or producer for advice given.
- 551 [~~(82)~~] (83) "Insurance holding company system" means a group of two or more  
552 affiliated persons, at least one of whom is an insurer.

553            [~~(83)~~] (84) (a) "Insurance producer" or "producer" means a person licensed or required  
554 to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

555            (b) With regards to the selling, soliciting, or negotiating of an insurance product to an  
556 insurance customer or an insured:

557            (i) "producer for the insurer" means a producer who is compensated directly or  
558 indirectly by an insurer for selling, soliciting, or negotiating any product of that insurer; and

559            (ii) "producer for the insured" means a producer who:

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

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

563            [~~(84)~~] (85) (a) "Insured" means a person to whom or for whose benefit an insurer  
564 makes a promise in an insurance policy and includes:

565            (i) policyholders;

566            (ii) subscribers;

567            (iii) members; and

568            (iv) beneficiaries.

569            (b) The definition in Subsection [~~(84)~~] (85)(a):

570            (i) applies only to this title; and

571            (ii) does not define the meaning of this word as used in insurance policies or  
572 certificates.

573            [~~(85)~~] (86) (a) (i) "Insurer" means any person doing an insurance business as a  
574 principal including:

575            (A) fraternal benefit societies;

576            (B) issuers of gift annuities other than those specified in Subsections 31A-22-1305(2)  
577 and (3);

578            (C) motor clubs;

579            (D) employee welfare plans; and

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

582            (ii) "Insurer" does not include a governmental entity, as defined in Section 63-30-2, to  
583 the extent it is engaged in the activities described in Section 31A-12-107.

- 584 (b) "Admitted insurer" is defined in Subsection [~~(153)~~] (154)(b).
- 585 (c) "Alien insurer" is defined in Subsection (7).
- 586 (d) "Authorized insurer" is defined in Subsection [~~(153)~~] (154)(b).
- 587 (e) "Domestic insurer" is defined in Subsection (47).
- 588 (f) "Foreign insurer" is defined in Subsection [~~(61)~~] (62).
- 589 (g) "Nonadmitted insurer" is defined in Subsection [~~(153)~~] (154)(a).
- 590 (h) "Unauthorized insurer" is defined in Subsection [~~(153)~~] (154)(a).
- 591 [~~(86)~~] (87) "Interinsurance exchange" is defined in Subsection [~~(135)~~] (136).
- 592 [~~(87)~~] (88) "Involuntary unemployment insurance" means insurance:
  - 593 (a) offered in connection with an extension of credit;
  - 594 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
  - 595 coming due on a:
    - 596 (i) specific loan; or
    - 597 (ii) credit transaction.
- 598 [~~(88)~~] (89) "Large employer," in connection with a health benefit plan, means an
- 599 employer who, with respect to a calendar year and to a plan year:
  - 600 (a) employed an average of at least 51 eligible employees on each business day during
  - 601 the preceding calendar year; and
  - 602 (b) employs at least two employees on the first day of the plan year.
- 603 [~~(89)~~] (90) (a) Except for a retainer contract or legal assistance described in Section
- 604 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for
- 605 specified legal expenses.
  - 606 (b) "Legal expense insurance" includes arrangements that create reasonable
  - 607 expectations of enforceable rights.
  - 608 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
  - 609 legal services incidental to other insurance coverages.
- 610 [~~(90)~~] (91) (a) "Liability insurance" means insurance against liability:
  - 611 (i) for death, injury, or disability of any human being, or for damage to property,
  - 612 exclusive of the coverages under:
    - 613 (A) Subsection [~~(100)~~] (101) for medical malpractice insurance;
    - 614 (B) Subsection [~~(127)~~] (128) for professional liability insurance; and

- 615 (C) Subsection [~~(157)~~] (158) for workers' compensation insurance;
- 616 (ii) for medical, hospital, surgical, and funeral benefits to persons other than the
- 617 insured who are injured, irrespective of legal liability of the insured, when issued with or
- 618 supplemental to insurance against legal liability for the death, injury, or disability of human
- 619 beings, exclusive of the coverages under:
- 620 (A) Subsection [~~(100)~~] (101) for medical malpractice insurance;
- 621 (B) Subsection [~~(127)~~] (128) for professional liability insurance; and
- 622 (C) Subsection [~~(157)~~] (158) for workers' compensation insurance;
- 623 (iii) for loss or damage to property resulting from accidents to or explosions of boilers,
- 624 pipes, pressure containers, machinery, or apparatus;
- 625 (iv) for loss or damage to any property caused by the breakage or leakage of sprinklers,
- 626 water pipes and containers, or by water entering through leaks or openings in buildings; or
- 627 (v) for other loss or damage properly the subject of insurance not within any other kind
- 628 or kinds of insurance as defined in this chapter, if such insurance is not contrary to law or
- 629 public policy.
- 630 (b) "Liability insurance" includes:
- 631 (i) vehicle liability insurance as defined in Subsection [~~(155)~~] (156);
- 632 (ii) residential dwelling liability insurance as defined in Subsection [~~(138)~~] (139); and
- 633 (iii) making inspection of, and issuing certificates of inspection upon, elevators,
- 634 boilers, machinery, and apparatus of any kind when done in connection with insurance on
- 635 them.
- 636 [~~(91)~~] (92) (a) "License" means the authorization issued by the commissioner to engage
- 637 in some activity that is part of or related to the insurance business.
- 638 (b) "License" includes certificates of authority issued to insurers.
- 639 [~~(92)~~] (93) (a) "Life insurance" means insurance on human lives and insurances
- 640 pertaining to or connected with human life.
- 641 (b) The business of life insurance includes:
- 642 (i) granting death benefits;
- 643 (ii) granting annuity benefits;
- 644 (iii) granting endowment benefits;
- 645 (iv) granting additional benefits in the event of death by accident;

646 (v) granting additional benefits to safeguard the policy against lapse in the event of  
647 disability; and

648 (vi) providing optional methods of settlement of proceeds.

649 [~~93~~] (94) "Limited license" means a license that:

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

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

652 [~~94~~] (95) "Limited line credit insurance" includes the following forms of insurance:

653 (a) credit life;

654 (b) credit accident and health;

655 (c) credit property;

656 (d) credit unemployment;

657 (e) involuntary unemployment;

658 (f) mortgage life;

659 (g) mortgage guaranty;

660 (h) mortgage accident and health;

661 (i) guaranteed automobile protection; and

662 (j) any other form of insurance offered in connection with an extension of credit that:

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

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

666 [~~95~~] (96) "Limited line credit insurance producer" means a person who sells, solicits,  
667 or negotiates one or more forms of limited line credit insurance coverage to individuals through  
668 a master, corporate, group, or individual policy.

669 [~~96~~] (97) "Limited line insurance" includes:

670 (a) bail bond;

671 (b) limited line credit insurance;

672 (c) legal expense insurance;

673 (d) motor club insurance;

674 (e) rental car-related insurance;

675 (f) travel insurance; and

676 (g) any other form of limited insurance that the commissioner determines by rule

677 should be designated a form of limited line insurance.

678 [~~(97)~~] (98) "Limited lines authority" includes:

679 (a) the lines of insurance listed in Subsection [~~(96)~~] (97); and

680 (b) a customer service representative.

681 [~~(98)~~] (99) "Limited lines producer" means a person who sells, solicits, or negotiates  
682 limited lines insurance.

683 [~~(99)~~] (100) (a) "Long-term care insurance" means an insurance policy or rider  
684 advertised, marketed, offered, or designated to provide coverage:

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

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

687 (A) expenses incurred;

688 (B) indemnity;

689 (C) prepayment; or

690 (D) another method;

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

692 (A) diagnostic;

693 (B) preventative;

694 (C) therapeutic;

695 (D) rehabilitative;

696 (E) maintenance; or

697 (F) personal care; and

698 (iv) that may be issued by:

699 (A) an insurer;

700 (B) a fraternal benefit society;

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

702 (II) a medical service corporation;

703 (D) a prepaid health plan;

704 (E) a health maintenance organization; or

705 (F) an entity similar to the entities described in Subsections [~~(99)~~] (100)(a)(iv)(A)

706 through (E) to the extent that the entity is otherwise authorized to issue life or health care  
707 insurance.

- 708 (b) "Long-term care insurance" includes:
- 709 (i) any of the following that provide directly or supplement long-term care insurance:
- 710 (A) a group or individual annuity or rider; or
- 711 (B) a life insurance policy or rider;
- 712 (ii) a policy or rider that provides for payment of benefits based on:
- 713 (A) cognitive impairment; or
- 714 (B) functional capacity; or
- 715 (iii) a qualified long-term care insurance contract.
- 716 (c) "Long-term care insurance" does not include:
- 717 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
- 718 (ii) basic hospital expense coverage;
- 719 (iii) basic medical/surgical expense coverage;
- 720 (iv) hospital confinement indemnity coverage;
- 721 (v) major medical expense coverage;
- 722 (vi) income replacement or related asset-protection coverage;
- 723 (vii) accident only coverage;
- 724 (viii) coverage for a specified:
- 725 (A) disease; or
- 726 (B) accident;
- 727 (ix) limited benefit health coverage; or
- 728 (x) a life insurance policy that accelerates the death benefit to provide the option of a
- 729 lump sum payment:
- 730 (A) if the following are not conditioned on the receipt of long-term care:
- 731 (I) benefits; or
- 732 (II) eligibility; and
- 733 (B) the coverage is for one or more the following qualifying events:
- 734 (I) terminal illness;
- 735 (II) medical conditions requiring extraordinary medical intervention; or
- 736 (III) permanent institutional confinement.
- 737 [~~(100)~~] (101) "Medical malpractice insurance" means insurance against legal liability
- 738 incident to the practice and provision of medical services other than the practice and provision

739 of dental services.

740 ~~[(101)]~~ (102) "Member" means a person having membership rights in an insurance  
741 corporation.

742 ~~[(102)]~~ (103) "Minimum capital" or "minimum required capital" means the capital that  
743 must be constantly maintained by a stock insurance corporation as required by statute.

744 ~~[(103)]~~ (104) "Mortgage accident and health insurance" means insurance offered in  
745 connection with an extension of credit that provides indemnity for payments coming due on a  
746 mortgage while the debtor is disabled.

747 ~~[(104)]~~ (105) "Mortgage guaranty insurance" means surety insurance under which  
748 mortgagees and other creditors are indemnified against losses caused by the default of debtors.

749 ~~[(105)]~~ (106) "Mortgage life insurance" means insurance on the life of a debtor in  
750 connection with an extension of credit that pays if the debtor dies.

751 ~~[(106)]~~ (107) "Motor club" means a person:

752 (a) licensed under:

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

754 (ii) Chapter 11, Motor Clubs; or

755 (iii) Chapter 14, Foreign Insurers; and

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

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

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

759 (iii) trip reimbursement, towing services, emergency road services, stolen automobile  
760 services, a combination of these services, or any other services given in Subsections

761 31A-11-102(1)(b) through (f).

762 ~~[(107)]~~ (108) "Mutual" means a mutual insurance corporation.

763 ~~[(108)]~~ (109) "Network plan" means health care insurance:

764 (a) that is issued by an insurer; and

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

768 ~~[(109)]~~ (110) "Nonparticipating" means a plan of insurance under which the insured is  
769 not entitled to receive dividends representing shares of the surplus of the insurer.

770 [~~(110)~~] (111) "Ocean marine insurance" means insurance against loss of or damage to:

771 (a) ships or hulls of ships;

772 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys,

773 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia

774 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

775 (c) earnings such as freight, passage money, commissions, or profits derived from

776 transporting goods or people upon or across the oceans or inland waterways; or

777 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,

778 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons

779 in connection with maritime activity.

780 [~~(111)~~] (112) "Order" means an order of the commissioner.

781 [~~(112)~~] (113) "Outline of coverage" means a summary that explains an accident and

782 health insurance policy.

783 [~~(113)~~] (114) "Participating" means a plan of insurance under which the insured is

784 entitled to receive dividends representing shares of the surplus of the insurer.

785 [~~(114)~~] (115) "Participation," as used in a health benefit plan, means a requirement

786 relating to the minimum percentage of eligible employees that must be enrolled in relation to

787 the total number of eligible employees of an employer reduced by each eligible employee who

788 voluntarily declines coverage under the plan because the employee has other group health care

789 insurance coverage.

790 [~~(115)~~] (116) "Person" includes an individual, partnership, corporation, incorporated or

791 unincorporated association, joint stock company, trust, limited liability company, reciprocal,

792 syndicate, or any similar entity or combination of entities acting in concert.

793 [~~(116)~~] (117) "Personal lines insurance" means property and casualty insurance

794 coverage sold for primarily noncommercial purposes to:

795 (a) individuals; and

796 (b) families.

797 [~~(117)~~] (118) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

798 [~~(118)~~] (119) "Plan year" means:

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

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

- 801 (ii) a summary plan description of a group health plan;
- 802 (b) if the plan document or summary plan description does not designate a plan year or
- 803 there is no plan document or summary plan description:
- 804 (i) the year used to determine deductibles or limits;
- 805 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;
- 806 or
- 807 (iii) the employer's taxable year if:
- 808 (A) the plan does not impose deductibles or limits on a yearly basis; and
- 809 (B) (I) the plan is not insured; or
- 810 (II) the insurance policy is not renewed on an annual basis; or
- 811 (c) in a case not described in Subsection [~~(118)~~] (119)(a) or (b), the calendar year.
- 812 [~~(119)~~] (120) (a) (i) "Policy" means any document, including attached endorsements
- 813 and riders, purporting to be an enforceable contract, which memorializes in writing some or all
- 814 of the terms of an insurance contract.
- 815 (ii) "Policy" includes a service contract issued by:
- 816 (A) a motor club under Chapter 11, Motor Clubs;
- 817 (B) a service contract provided under Chapter 6a, Service Contracts; and
- 818 (C) a corporation licensed under:
- 819 (I) Chapter 7, Nonprofit Health Service Insurance Corporations; or
- 820 (II) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
- 821 (iii) "Policy" does not include:
- 822 (A) a certificate under a group insurance contract; or
- 823 (B) a document that does not purport to have legal effect.
- 824 (b) (i) "Group insurance policy" means a policy covering a group of persons that is
- 825 issued to a policyholder on behalf of the group, for the benefit of group members who are
- 826 selected under procedures defined in the policy or in agreements which are collateral to the
- 827 policy.
- 828 (ii) A group insurance policy may include members of the policyholder's family or
- 829 dependents.
- 830 (c) "Blanket insurance policy" means a group policy covering classes of persons
- 831 without individual underwriting, where the persons insured are determined by definition of the

832 class with or without designating the persons covered.

833 ~~[(120)]~~ (121) "Policyholder" means the person who controls a policy, binder, or oral  
834 contract by ownership, premium payment, or otherwise.

835 ~~[(121)]~~ (122) "Policy illustration" means a presentation or depiction that includes  
836 nonguaranteed elements of a policy of life insurance over a period of years.

837 ~~[(122)]~~ (123) "Policy summary" means a synopsis describing the elements of a life  
838 insurance policy.

839 ~~[(123)]~~ (124) "Preexisting condition," in connection with a health benefit plan, means:

840 (a) a condition for which medical advice, diagnosis, care, or treatment was  
841 recommended or received during the six months immediately preceding the earlier of:

842 (i) the enrollment date; or

843 (ii) the effective date of coverage; or

844 (b) for an individual insurance policy, a pregnancy existing on the effective date of  
845 coverage.

846 ~~[(124)]~~ (125) (a) "Premium" means the monetary consideration for an insurance  
847 policy~~[-and]~~.

848 (b) "Premium" includes, however designated:

849 (i) assessments~~[-]~~;

850 (ii) membership fees~~[-]~~;

851 (iii) required contributions~~[-]~~; or

852 (iv) monetary consideration~~[-, however designated]~~.

853 ~~[(b)]~~ (c) (i) Consideration paid to third party administrators for their services is not  
854 "premium~~[-]~~." ~~[though amounts]~~

855 (ii) Amounts paid by third party administrators to insurers for insurance on the risks  
856 administered by the third party administrators are "premium."

857 ~~[(125)]~~ (126) "Principal officers" of a corporation means the officers designated under  
858 Subsection 31A-5-203(3).

859 ~~[(126)]~~ (127) "Proceedings" includes actions and special statutory proceedings.

860 ~~[(127)]~~ (128) "Professional liability insurance" means insurance against legal liability  
861 incident to the practice of a profession and provision of any professional services.

862 ~~[(128)]~~ (129) "Property insurance" means insurance against loss or damage to real or

863 personal property of every kind and any interest in that property, from all hazards or causes,  
864 and against loss consequential upon the loss or damage including vehicle comprehensive and  
865 vehicle physical damage coverages, but excluding inland marine insurance and ocean marine  
866 insurance as defined under Subsections [~~(76)~~] (77) and [~~(110)~~] (111).

867 [~~(129)~~] (130) "Qualified long-term care insurance contract" or "federally tax qualified  
868 long-term care insurance contract" means:

869 (a) an individual or group insurance contract that meets the requirements of Section  
870 7702B(b), Internal Revenue Code; or

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

872 (i) (A) by rider; or

873 (B) as a part of the contract; and

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

875 [~~(130)~~] (131) "Qualified United States financial institution" means an institution that:

876 (a) is:

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

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

880 (b) is regulated, supervised, and examined by United States federal or state authorities  
881 having regulatory authority over banks and trust companies; and

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

885 (i) the commissioner by rule; or

886 (ii) the Securities Valuation Office of the National Association of Insurance

887 Commissioners.

888 [~~(131)~~] (132) (a) "Rate" means:

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

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

892 (A) a single number; or

893 (B) a pure premium rate, adjusted before any application of individual risk variations

894 based on loss or expense considerations to account for the treatment of:

895 (I) expenses;

896 (II) profit; and

897 (III) individual insurer variation in loss experience.

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

899 [~~132~~] (133) (a) Except as provided in Subsection [~~132~~] (133)(b), "rate service  
900 organization" means any person who assists insurers in rate making or filing by:

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

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

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

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

905 (i) an employee of an insurer;

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

907 (iii) a joint underwriting group; or

908 (iv) a natural person serving as an actuarial or legal consultant.

909 [~~133~~] (134) "Rating manual" means any of the following used to determine initial and  
910 renewal policy premiums:

911 (a) a manual of rates;

912 (b) classifications;

913 (c) rate-related underwriting rules; and

914 (d) rating formulas that describe steps, policies, and procedures for determining initial  
915 and renewal policy premiums.

916 [~~134~~] (135) "Received by the department" means:

917 (a) except as provided in Subsection [~~134~~] (135)(b), the date delivered to and  
918 stamped received by the department, whether delivered:

919 (i) in person; or

920 (ii) electronically; and

921 (b) if delivered to the department by a delivery service, the delivery service's postmark  
922 date or pick-up date unless otherwise stated in:

923 (i) statute;

924 (ii) rule; or

925 (iii) a specific filing order.

926 ~~[(135)]~~ (136) "Reciprocal" or "interinsurance exchange" means any unincorporated  
927 association of persons:

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

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

931 ~~[(136)]~~ (137) "Reinsurance" means an insurance transaction where an insurer, for  
932 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to  
933 reinsurance transactions, this title sometimes refers to:

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

935 (b) the insurer assuming the risk as the:

936 (i) "assuming insurer"; or

937 (ii) "assuming reinsurer."

938 ~~[(137)]~~ (138) "Reinsurer" means any person~~[- firm, association, or corporation]~~  
939 licensed in this state as an insurer with the authority to assume reinsurance.

940 ~~[(138)]~~ (139) "Residential dwelling liability insurance" means insurance against  
941 liability resulting from or incident to the ownership, maintenance, or use of a residential  
942 dwelling that is a detached single family residence or multifamily residence up to four units.

943 ~~[(139)]~~ (140) "Retrocession" means reinsurance with another insurer of a liability  
944 assumed under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another  
945 insurer part of a liability assumed under a reinsurance contract.

946 ~~[(140)]~~ (141) "Rider" means an endorsement to:

947 (a) an insurance policy; or

948 (b) an insurance certificate.

949 ~~[(141)]~~ (142) (a) "Security" means any:

950 (i) note;

951 (ii) stock;

952 (iii) bond;

953 (iv) debenture;

954 (v) evidence of indebtedness;

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

- 956 (vii) collateral-trust certificate;
- 957 (viii) preorganization certificate or subscription;
- 958 (ix) transferable share;
- 959 (x) investment contract;
- 960 (xi) voting trust certificate;
- 961 (xii) certificate of deposit for a security;
- 962 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
- 963 payments out of production under such a title or lease;
- 964 (xiv) commodity contract or commodity option;
- 965 (xv) any certificate of interest or participation in, temporary or interim certificate for,
- 966 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
- 967 in Subsections [~~(141)~~] (142)(a)(i) through (xiv); or
- 968 (xvi) any other interest or instrument commonly known as a security.
- 969 (b) "Security" does not include:
- 970 (i) any [~~insurance or endowment policy or annuity contract~~] of the following under
- 971 which an insurance company promises to pay money in a specific lump sum or periodically for
- 972 life or some other specified period[~~;~~ or]:
- 973 (A) insurance;
- 974 (B) endowment policy; or
- 975 (C) annuity contract; or
- 976 (ii) a burial certificate or burial contract.
- 977 [~~(142)~~] (143) "Self-insurance" means any arrangement under which a person provides
- 978 for spreading its own risks by a systematic plan.
- 979 (a) Except as provided in this Subsection [~~(142)~~] (143), "self-insurance" does not
- 980 include an arrangement under which a number of persons spread their risks among themselves.
- 981 (b) "Self-insurance" [~~does include~~] includes:
- 982 (i) an arrangement by which a governmental entity, as defined in Section 63-30-2,
- 983 undertakes to indemnify its employees for liability arising out of the employees' employment[-
- 984 (c) Self-insurance does include]; and
- 985 (ii) an arrangement by which a person with a managed program of self-insurance and
- 986 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or

987 employees for liability or risk which is related to the relationship or employment.

988 ~~[(143)]~~ (c) "Self-insurance" does not include any arrangement with independent  
989 contractors.

990 ~~[(143)]~~ (144) "Sell" means to exchange a contract of insurance:

991 (a) by any means;

992 (b) for money or its equivalent; and

993 (c) on behalf of an insurance company.

994 ~~[(144)]~~ (145) "Short-term care insurance" means any insurance policy or rider  
995 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care  
996 insurance but that provides coverage for less than 12 consecutive months for each covered  
997 person.

998 ~~[(145)]~~ (146) "Small employer," in connection with a health benefit plan, means an  
999 employer who, with respect to a calendar year and to a plan year:

1000 (a) employed an average of at least two employees but not more than 50 eligible  
1001 employees on each business day during the preceding calendar year; and

1002 (b) employs at least two employees on the first day of the plan year.

1003 ~~[(146)]~~ (147) (a) "Subsidiary" of a person means an affiliate controlled by that person  
1004 either directly or indirectly through one or more affiliates or intermediaries.

1005 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting  
1006 shares are owned by that person either alone or with its affiliates, except for the minimum  
1007 number of shares the law of the subsidiary's domicile requires to be owned by directors or  
1008 others.

1009 ~~[(147)]~~ (148) Subject to Subsection ~~[(78)]~~ (79)(b), "surety insurance" includes:

1010 (a) a guarantee against loss or damage resulting from failure of principals to pay or  
1011 perform their obligations to a creditor or other obligee;

1012 (b) bail bond insurance; and

1013 (c) fidelity insurance.

1014 ~~[(148)]~~ (149) (a) "Surplus" means the excess of assets over the sum of paid-in capital  
1015 and liabilities.

1016 (b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been  
1017 designated by the insurer as permanent.

1018 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require  
1019 that mutuals doing business in this state maintain specified minimum levels of permanent  
1020 surplus.

1021 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is  
1022 essentially the same as the minimum required capital requirement that applies to stock insurers.

1023 (c) "Excess surplus" means:

1024 (i) for life or accident and health insurers, health organizations, and property and  
1025 casualty insurers as defined in Section 31A-17-601, the lesser of:

1026 (A) that amount of an insurer's or health organization's total adjusted capital, as defined  
1027 in Subsection [~~(151)~~] (152), that exceeds the product of:

1028 (I) 2.5; and

1029 (II) the sum of the insurer's or health organization's minimum capital or permanent  
1030 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

1031 (B) that amount of an insurer's or health organization's total adjusted capital, as defined  
1032 in Subsection [~~(151)~~] (152), that exceeds the product of:

1033 (I) 3.0; and

1034 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

1035 (ii) for monoline mortgage guaranty insurers, financial guaranty insurers, and title  
1036 insurers, that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

1037 (A) 1.5; and

1038 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

1039 [~~(149)~~] (150) "Third party administrator" or "administrator" means any person who  
1040 collects charges or premiums from, or who, for consideration, adjusts or settles claims of  
1041 residents of the state in connection with insurance coverage, annuities, or service insurance  
1042 coverage, except:

1043 (a) a union on behalf of its members;

1044 (b) a person administering any:

1045 (i) pension plan subject to the federal Employee Retirement Income Security Act of  
1046 1974;

1047 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or

1048 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;

1049 (c) an employer on behalf of the employer's employees or the employees of one or  
1050 more of the subsidiary or affiliated corporations of the employer;

1051 (d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance  
1052 for which the insurer holds a license in this state; or

1053 (e) a person;

1054 (i) licensed or exempt from licensing under;

1055 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and  
1056 Reinsurance Intermediaries[;]; or

1057 (B) Chapter 26, Insurance Adjusters[;]; and

1058 (ii) whose activities are limited to those authorized under the license the person holds  
1059 or for which the person is exempt.

1060 [~~(150)~~] (151) "Title insurance" means the insuring, guaranteeing, or indemnifying of  
1061 owners of real or personal property or the holders of liens or encumbrances on that property, or  
1062 others interested in the property against loss or damage suffered by reason of liens or  
1063 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity  
1064 or unenforceability of any liens or encumbrances on the property.

1065 [~~(151)~~] (152) "Total adjusted capital" means the sum of an insurer's or health  
1066 organization's statutory capital and surplus as determined in accordance with:

1067 (a) the statutory accounting applicable to the annual financial statements required to be  
1068 filed under Section 31A-4-113; and

1069 (b) any other items provided by the RBC instructions, as RBC instructions is defined in  
1070 Section 31A-17-601.

1071 [~~(152)~~] (153) (a) "Trustee" means "director" when referring to the board of directors of  
1072 a corporation.

1073 (b) "Trustee," when used in reference to an employee welfare fund, means an  
1074 individual, firm, association, organization, joint stock company, or corporation, whether acting  
1075 individually or jointly and whether designated by that name or any other, that is charged with  
1076 or has the overall management of an employee welfare fund.

1077 [~~(153)~~] (154) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted  
1078 insurer" means an insurer:

1079 (i) not holding a valid certificate of authority to do an insurance business in this state;

1080 or

1081 (ii) transacting business not authorized by a valid certificate.

1082 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1083 (i) holding a valid certificate of authority to do an insurance business in this state; and

1084 (ii) transacting business as authorized by a valid certificate.

1085 [~~(154)~~] (155) "Underwrite" means the authority to accept or reject risk on behalf of the  
1086 insurer.

1087 [~~(155)~~] (156) "Vehicle liability insurance" means insurance against liability resulting  
1088 from or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of  
1089 vehicle comprehensive and vehicle physical damage coverages under Subsection [~~(128)~~] (129).

1090 [~~(156)~~] (157) "Voting security" means a security with voting rights, and includes any  
1091 security convertible into a security with a voting right associated with [it] the security.

1092 [~~(157)~~] (158) "Workers' compensation insurance" means:

1093 (a) insurance for indemnification of employers against liability for compensation based  
1094 on:

1095 (i) compensable accidental injuries; and

1096 (ii) occupational disease disability;

1097 (b) employer's liability insurance incidental to workers' compensation insurance and  
1098 written in connection with [it] workers' compensation insurance; and

1099 (c) insurance assuring to the persons entitled to workers' compensation benefits the  
1100 compensation provided by law.

1101 Section 2. Section **31A-2-205** is amended to read:

1102 **31A-2-205. Examination costs.**

1103 (1) (a) Except as provided in Subsection (3), [~~examinees that are insurers~~] an examinee  
1104 that is an insurer, rate service [~~organizations~~] organization, or the [~~subsidiaries~~] subsidiary of  
1105 either shall reimburse the [~~Insurance Department~~] department for the reasonable costs of  
1106 examinations made under Sections 31A-2-203 and 31A-2-204. The following costs shall be  
1107 reimbursed:

1108 (i) actual travel expenses;

1109 (ii) reasonable living expense allowance;

1110 (iii) compensation at reasonable rates for all professionals reasonably employed for the

1111 examination under Subsection (4);

1112 (iv) the administration and supervisory expense of;

1113 (A) the [~~Insurance Department~~] department; and

1114 (B) the attorney general's office; and

1115 (v) an amount necessary to cover fringe benefits authorized by the commissioner or  
1116 provided by law.

1117 (b) In determining rates, the commissioner shall consider the rates recommended [~~by~~  
1118 ~~the National Association of Insurance Commissioners~~] and outlined in the examination manual  
1119 sponsored by the [~~association~~] National Association of Insurance Commissioners.

1120 [~~(b)~~] (c) This Subsection (1) applies to a surplus lines [~~producers~~] producer to the  
1121 extent that the examinations are of [~~their~~] the surplus line producer's surplus lines business.

1122 (2) An insurer requesting the examination of one of its producers shall pay the cost of  
1123 the examination. Otherwise, the department shall pay the cost of examining [~~licensees~~] a  
1124 licensee other than those specified under Subsection (1).

1125 (3) (a) On the examinee's request or at the commissioner's discretion, the [~~Insurance~~  
1126 ~~Department~~] department may pay all or part of the costs of an examination whenever the  
1127 commissioner finds that because of the frequency of examinations or the financial condition of  
1128 the examinee, imposition of the costs would place an unreasonable burden on the examinee.

1129 (b) The commissioner shall include in [~~his~~] the commissioner's annual report  
1130 information about any instance in which the commissioner has applied this Subsection (3).

1131 (4) (a) [~~Technical experts~~] A technical expert employed under Subsection  
1132 31A-2-203(3) shall present to the commissioner a statement of all expenses incurred by [~~them~~]  
1133 the technical expert in conjunction with an examination.

1134 (b) The examined insurer shall, at the commissioner's direction, pay to the technical  
1135 experts or specialists the:

1136 (i) actual travel expenses[;];

1137 (ii) reasonable living expenses[;]; and

1138 (iii) compensation at customary rates for expenses necessarily incurred as approved by  
1139 the commissioner.

1140 (c) The examined insurer shall reimburse:

1141 (i) department examiners for their;

- 1142           (A) actual travel expenses; and
- 1143           (B) reasonable living expenses; and [~~shall reimburse~~]
- 1144           (ii) the department for the compensation of department examiners involved in the
- 1145 examination.
- 1146           (d) (i) The examined insurer shall certify the consolidated account of all charges and
- 1147 expenses for the examination. [~~One~~]
- 1148           (ii) The insurer shall:
- 1149           (A) retain a copy [~~shall be retained by the insurer and the other shall be filed~~] of the
- 1150 consolidated account; and
- 1151           (B) file a copy of the consolidated account with the department as a public record.
- 1152           (e) (i) An annual report of examination charges paid by examined insurers directly to
- 1153 persons employed under Subsection 31A-2-203(3) or to department examiners shall be
- 1154 included with the department's budget request[~~, but amounts~~].
- 1155           (f) Amounts paid directly by examined insurers to persons employed under Subsection
- 1156 31A-2-203(3) or to department examiners may not be deducted from the department's
- 1157 appropriation.
- 1158           (5) (a) The amount payable under Subsection (1) is due ten days after the examinee has
- 1159 been served with a detailed account of the costs.
- 1160           (b) Payments received by the department under this Subsection (5) shall be handled as
- 1161 provided by [~~Subsection~~] Section 31A-3-101.
- 1162           (6) (a) The commissioner may require an examinee under Subsection (1), or an insurer
- 1163 requesting an examination under Subsection (2), either before or during an examination, to
- 1164 make deposits with the state treasurer to pay the costs of examination.
- 1165           (b) Any deposit made under this Subsection (6) shall be held in trust by the state
- 1166 treasurer until applied to pay the [~~Insurance Department~~] department the costs payable under
- 1167 this section.
- 1168           (c) If a deposit made under this Subsection (6) exceeds examination costs, the state
- 1169 treasurer shall refund the surplus.
- 1170           (7) [~~Domestic insurers~~] A domestic insurer may offset the examination expenses paid
- 1171 under this section against premium taxes under Subsection 59-9-102(2).
- 1172           Section 3. Section **31A-2-207** is amended to read:

1173 **31A-2-207. Commissioner's records and reports.**

1174 (1) The commissioner shall maintain all [~~Insurance Department~~] department records  
1175 [~~which~~] that are:

1176 (a) required by law;

1177 (b) necessary for the effective operation of the department; or

1178 (c) necessary to maintain a full record of department activities.

1179 (2) The records of the department may be preserved, managed, stored, and made  
1180 available for review consistent with:

1181 (a) another Utah statute;

1182 (b) the rules made under Section 63-2-904;

1183 (c) the decisions of the State Records Committee made under Title 63, Chapter 2,  
1184 Government Records Access and Management Act; or

1185 (d) the needs of the public.

1186 (3) [~~No Insurance Department~~] A department record may not be destroyed, damaged,  
1187 or disposed of without:

1188 (a) authorization of the commissioner; and

1189 (b) compliance with all other applicable laws.

1190 (4) The commissioner shall maintain a permanent record of [~~his~~] the commissioner's  
1191 proceedings and important activities, including:

1192 (a) a concise statement of the condition of each insurer examined by [~~him~~]; the  
1193 commissioner; and

1194 (b) a record of all certificates of authority and licenses issued by [~~him~~] the  
1195 commissioner.

1196 (5) (a) Prior to October 1 of each year, the commissioner shall prepare an annual report  
1197 to the governor which shall include, for the preceding calendar year, the information  
1198 concerning the department and the insurance industry which the commissioner believes will be  
1199 useful to the governor and the public. [~~This~~]

1200 (b) The report required by this Subsection (5) shall include the information required  
1201 under Chapter 27 and Subsections 31A-2-106(2), 31A-2-205(3), and 31A-2-208(3).

1202 (c) The commissioner shall [~~have this~~] make the report [~~printed in sufficient numbers~~  
1203 ~~to meet the expected~~] required by this Subsection (5) available to the public and industry

1204 [~~demand for the document~~] in electronic format.

1205 (6) All department records and reports are open to public inspection unless specifically  
1206 provided otherwise by statute or by Title 63, Chapter 2, Government Records Access and  
1207 Management Act.

1208 (7) On request, the commissioner shall provide to any person certified or uncertified  
1209 copies of any record in the department that is open to public inspection.

1210 (8) Notwithstanding Subsection (6) and Title 63, Chapter 2, Government Records  
1211 Access and Management Act, the commissioner shall protect from disclosure any record, as  
1212 defined in Section 63-2-103, or other document received from an insurance regulator of  
1213 another jurisdiction:

1214 (a) at least to the same extent the record or document is protected from disclosure  
1215 under the laws applicable to the insurance regulator providing the record or document; or

1216 (b) under the same terms and conditions of confidentiality as the National Association  
1217 of Insurance Commissioners requires as a condition of participating in any of the National  
1218 Association of Insurance Commissioners' programs.

1219 Section 4. Section **31A-2-309** is amended to read:

1220 **31A-2-309. Service of process through state officer.**

1221 (1) The commissioner, or the lieutenant governor when the subject proceeding is  
1222 brought by the state, is the agent for receipt of service of any summons, notice, order, pleading,  
1223 or any other legal process relating to a Utah court or administrative agency upon the following:

1224 (a) all insurers authorized to do business in this state, while authorized to do business  
1225 in this state, and thereafter in any proceeding arising from or related to any transaction having a  
1226 connection with this state;

1227 (b) all surplus lines insurers for any proceeding arising out of a contract of insurance  
1228 that is subject to the surplus lines law, or out of a certificate, cover note, or other confirmation  
1229 of that type of insurance;

1230 (c) all unauthorized insurers or other persons assisting unauthorized insurers under  
1231 Subsection 31A-15-102(1) by doing an act specified in Subsection 31A-15-102(2), for a  
1232 proceeding arising out of the transaction that is subject to the unauthorized insurance law;

1233 (d) any nonresident producer, consultant, adjuster, and third party administrator, while  
1234 authorized to do business in this state, and thereafter in any proceeding arising from or related

1235 to any transaction having a connection with this state; and

1236 (e) any reinsurer submitting to the commissioner's jurisdiction under Subsection  
1237 31A-17-404(7).

1238 (2) ~~[Each]~~ The following is considered to have irrevocably appointed the commissioner  
1239 and lieutenant governor as that person's agents in accordance with Subsection (1):

1240 (a) each licensed insurer by applying for and receiving a certificate of authority[;];

1241 (b) each surplus lines insurer by entering into a contract subject to the surplus lines  
1242 law[;];

1243 (c) each unauthorized insurer by doing in this state any of the acts prohibited by  
1244 Section ~~[31A-15-101;]~~ 31A-15-103; and

1245 (d) each nonresident producer, consultant, adjuster, and third party administrator [~~is~~  
1246 ~~considered to have irrevocably appointed the commissioner and lieutenant governor as his~~  
1247 ~~agents in accordance with Subsection (1)~~].

1248 (3) The commissioner and lieutenant governor are also agents for the executors,  
1249 administrators or personal representatives, receivers, trustees, or other successors in interest of  
1250 the persons specified under Subsection (1).

1251 (4) Litigants serving process on the commissioner or lieutenant governor under this  
1252 section shall pay the fee applicable under Section 31A-3-103.

1253 (5) The right to substituted service under this section does not limit the right to serve a  
1254 summons, notice, order, pleading, demand, or other process upon a person in any other manner  
1255 provided by law.

1256 Section 5. Section **31A-4-113** is amended to read:

1257 **31A-4-113. Annual statements.**

1258 (1) (a) Each authorized insurer shall annually, on or before March 1, file with the  
1259 commissioner a true statement of [~~its~~] the authorized insurer's financial condition, transactions,  
1260 and affairs as of December 31 of the preceding year.

1261 (b) The statement required by Subsection (1)(a) shall be:

1262 (i) verified by the oaths of at least two of the insurer's principal officers; and

1263 (ii) in the general form and provide the information as prescribed by the commissioner  
1264 by rule.

1265 (c) The commissioner may, for good cause shown, extend the date for filing the

1266 statement required by Subsection (1)(a)[, except that the deadline for filing fee payment may  
1267 ~~not be extended~~].

1268 (2) The annual statement of an alien insurer shall:

1269 (a) relate only to [its] the alien insurer's transactions and affairs in the United States

1270 unless the commissioner requires otherwise; and

1271 (b) be verified by:

1272 (i) the insurer's United States manager; or

1273 (ii) the insurer's authorized officers.

1274 Section 6. Section **31A-8-103** is amended to read:

1275 **31A-8-103. Applicability to other provisions of law.**

1276 (1) (a) Except for exemptions specifically granted under this title, an organization is  
1277 subject to regulation under all of the provisions of this title.

1278 (b) Notwithstanding any provision of this title, an organization licensed under this  
1279 chapter:

1280 (i) is wholly exempt from:

1281 (A) Chapter 7, Nonprofit Health Service Insurance Corporations;

1282 (B) Chapter 9, Insurance Fraternal;

1283 (C) Chapter 10, Annuities;

1284 (D) Chapter 11, Motor Clubs;

1285 (E) Chapter 12, State Risk Management Fund;

1286 (F) Chapter 13, Employee Welfare Funds and Plans;

1287 (G) Chapter 19a, Utah Rate Regulation Act; and

1288 (H) Chapter 28, Guaranty Associations; and

1289 (ii) is not subject to:

1290 (A) Chapter 3, Department Funding, Fees, and Taxes, except for Part I;

1291 (B) Section 31A-4-107;

1292 (C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for  
1293 provisions specifically made applicable by this chapter;

1294 (D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by  
1295 this chapter;

1296 (E) Chapter 17, Determination of Financial Condition, except:

- 1297 (I) Parts II and VI; or  
1298 (II) as made applicable by the commissioner by rule consistent with this chapter;  
1299 (F) Chapter 18, Investments, except as made applicable by the commissioner by rule  
1300 consistent with this chapter; and  
1301 (G) Chapter 22, Contracts in Specific Lines, except for Parts VI, VII, and XII.
- 1302 (2) The commissioner may by rule waive other specific provisions of this title that the  
1303 commissioner considers inapplicable to health maintenance organizations or limited health  
1304 plans, upon a finding that the waiver will not endanger the interests of:
- 1305 (a) enrollees;  
1306 (b) investors; or  
1307 (c) the public.
- 1308 (3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16,  
1309 Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as  
1310 specifically made applicable by:
- 1311 (a) this chapter;  
1312 (b) a provision referenced under this chapter; or  
1313 (c) a rule adopted by the commissioner to deal with corporate law issues of health  
1314 maintenance organizations that are not settled under this chapter.
- 1315 (4) (a) Whenever in this chapter, Chapter 5, or Chapter 14 is made applicable to an  
1316 organization, the application is:
- 1317 (i) of those provisions that apply to a mutual corporation if the organization is  
1318 nonprofit; and  
1319 (ii) of those that apply to a stock corporation if the organization is for profit.
- 1320 (b) When Chapter 5 or 14 is made applicable to an organization under this chapter,  
1321 "mutual" means nonprofit organization.
- 1322 (5) Solicitation of enrollees by an organization is not a violation of any provision of  
1323 law relating to solicitation or advertising by health professionals if that solicitation is made in  
1324 accordance with:
- 1325 (a) this chapter; and  
1326 (b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and  
1327 Reinsurance Intermediaries.

1328 (6) This title does not prohibit any health maintenance organization from meeting the  
1329 requirements of any federal law that enables the health maintenance organization to:

1330 (a) receive federal funds; or

1331 (b) obtain or maintain federal qualification status.

1332 (7) Except as provided in Section 31A-8-501, an organization is exempt from statutes  
1333 in this title or department rules that restrict or limit the organization's freedom of choice in  
1334 contracting with or selecting health care providers, including Section 31A-22-618.

1335 (8) An organization is exempt from the assessment or payment of premium taxes  
1336 imposed by Sections 59-9-101 through 59-9-104.

1337 Section 7. Section **31A-16-103** is amended to read:

1338 **31A-16-103. Acquisition of control of or merger with domestic insurer --**  
1339 **Required filings -- Content of statement -- Alternative filing materials -- Criminal**  
1340 **background information -- Approval by commissioner -- Dissenting shareholders --**  
1341 **Violations -- Jurisdiction, consent to service of process.**

1342 (1) (a) A person may not take the actions described in Subsections (1)(b) or (c) unless,  
1343 at the time any offer, request, or invitation is made or any such agreement is entered into, or  
1344 prior to the acquisition of securities if no offer or agreement is involved:

1345 (i) the person files with the commissioner a statement containing the information  
1346 required by this section;

1347 (ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the  
1348 insurer; and

1349 (iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.

1350 (b) Unless the person complies with Subsection (1)(a), a person other than the issuer  
1351 may not make a tender offer for, a request or invitation for tenders of, or enter into any  
1352 agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise,  
1353 any voting security of a domestic insurer if after the acquisition, the person would directly,  
1354 indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.

1355 (c) Unless the person complies with Subsection (1)(a), a person may not enter into an  
1356 agreement to merge with or otherwise to acquire control of:

1357 (i) a domestic insurer; or

1358 (ii) any person controlling a domestic insurer.

1359 (d) (i) For purposes of this section, a domestic insurer includes any person controlling a  
1360 domestic insurer unless the person as determined by the commissioner is either directly or  
1361 through its affiliates primarily engaged in business other than the business of insurance.

1362 (ii) The controlling person described in Subsection (1)(d)(i) shall file with the  
1363 commissioner a preacquisition notification containing the information required in Subsection  
1364 (2) 30 calendar days before the proposed effective date of the acquisition.

1365 (iii) For the purposes of this section, "person" does not include any securities broker  
1366 ~~[holding]~~ that in the usual and customary brokers function holds less than 20% of:

1367 (A) the voting securities of an insurance company; or ~~[of]~~

1368 (B) any person that controls an insurance company ~~[in the usual and customary brokers~~  
1369 ~~function]~~.

1370 (iv) This section applies to all domestic insurers and other entities licensed under  
1371 Chapters 5, 7, 8, 9, and 11.

1372 (e) (i) An agreement for acquisition of control or merger as contemplated by this  
1373 Subsection (1) is not valid or enforceable unless the agreement:

1374 (A) is in writing; and

1375 (B) includes a provision that the agreement is subject to the approval of the  
1376 commissioner upon the filing of any applicable statement required under this chapter.

1377 (ii) A written agreement for acquisition or control that includes the provision described  
1378 in Subsection (1)(e)(i) satisfies the requirements of this Subsection (1).

1379 (2) The statement to be filed with the commissioner under Subsection (1) shall be  
1380 made under oath or affirmation and shall contain the following information:

1381 (a) the name and address of the "acquiring party," which means each person by whom  
1382 or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to  
1383 be effected; and

1384 (i) if the person is an individual:

1385 (A) the person's principal occupation;

1386 (B) a listing of all offices and positions held by the person during the past five years;

1387 and

1388 (C) any conviction of crimes other than minor traffic violations during the past ten  
1389 years; and

- 1390 (ii) if the person is not an individual:
- 1391 (A) a report of the nature of its business operations during:
- 1392 (I) the past five years; or
- 1393 (II) for any lesser period as the person and any of its predecessors has been in
- 1394 existence;
- 1395 (B) an informative description of the business intended to be done by the person and
- 1396 the person's subsidiaries;
- 1397 (C) a list of all individuals who are or who have been selected to become directors or
- 1398 executive officers of the person, or individuals who perform, or who will perform functions
- 1399 appropriate to such positions; and
- 1400 (D) for each individual described in Subsection (2)(a)(ii)(C), the information required
- 1401 by Subsection (2)(a)(i)~~(A)~~ for each individual;
- 1402 (b) (i) the source, nature, and amount of the consideration used or to be used in
- 1403 effecting the merger or acquisition of control;
- 1404 (ii) a description of any transaction in which funds were or are to be obtained for ~~that~~
- 1405 the purpose of effecting the merger or acquisition of control, including any pledge of:
- 1406 (A) the insurer's stock; or
- 1407 (B) the stock of any of ~~its~~ the insurer's subsidiaries or controlling affiliates; and
- 1408 (iii) the identity of persons furnishing the consideration;
- 1409 (c) (i) fully audited financial information, or other financial information considered
- 1410 acceptable by the commissioner, of the earnings and financial condition of each acquiring party
- 1411 for;
- 1412 (A) the preceding five fiscal years of each acquiring party~~;~~; or ~~for~~
- 1413 (B) any lesser period the acquiring party and any of its predecessors shall have been in
- 1414 existence~~;~~; and ~~similar~~
- 1415 (ii) unaudited information;
- 1416 (A) similar to the information described in Subsection (2)(c)(i); and
- 1417 (B) prepared within the 90 days prior to the filing of the statement;
- 1418 (d) any plans or proposals which each acquiring party may have to:
- 1419 (i) liquidate the insurer;
- 1420 (ii) sell its assets;

- 1421 (iii) merge or consolidate the insurer with any person; or  
1422 (iv) make any other material change in the insurer's;  
1423 (A) business[;];  
1424 (B) corporate structure[;]; or  
1425 (C) management;  
1426 (e) (i) the number of shares of any security referred to in Subsection (1) that each  
1427 acquiring party proposes to acquire;  
1428 (ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in  
1429 Subsection (1); and  
1430 (iii) a statement as to the method by which the fairness of the proposal was arrived at;  
1431 (f) the amount of each class of any security referred to in Subsection (1) that:  
1432 (i) is beneficially owned; or  
1433 (ii) concerning which there is a right to acquire beneficial ownership by each acquiring  
1434 party;  
1435 (g) a full description of any contract, arrangement, or understanding with respect to any  
1436 security referred to in Subsection (1) in which any acquiring party is involved, including:  
1437 (i) the transfer of any of the securities;  
1438 (ii) joint ventures;  
1439 (iii) loan or option arrangements;  
1440 (iv) puts or calls;  
1441 (v) guarantees of loans;  
1442 (vi) guarantees against loss or guarantees of profits;  
1443 (vii) division of losses or profits; or  
1444 (viii) the giving or withholding of proxies;  
1445 (h) a description of the purchase by any acquiring party of any security referred to in  
1446 Subsection (1) during the 12 calendar months preceding the filing of the statement including:  
1447 (i) the dates of purchase;  
1448 (ii) the names of the purchasers; and  
1449 (iii) the consideration paid or agreed to be paid for the purchase;  
1450 (i) a description of;  
1451 (i) any recommendations to purchase by any acquiring party any security referred to in

1452 Subsection (1) made during the 12 calendar months preceding the filing of the statement; or  
1453       (ii) any recommendations made by anyone based upon interviews or at the suggestion  
1454 of the acquiring party;

1455       (j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange  
1456 offers for, and agreements to acquire or exchange any securities referred to in Subsection (1);  
1457 and

1458       (ii) if distributed, copies of additional soliciting material relating to the transactions  
1459 described in Subsection (2)(j)(i);

1460       (k) (i) the term of any agreement, contract, or understanding made with, or proposed to  
1461 be made with, any broker-dealer as to solicitation of securities referred to in Subsection (1) for  
1462 tender; and

1463       (ii) the amount of any fees, commissions, or other compensation to be paid to  
1464 broker-dealers with regard to any agreement, contract, or understanding described in  
1465 Subsection (2)(k)(i); and

1466       (l) any additional information the commissioner requires by rule, which the  
1467 commissioner determines to be:

1468           (i) necessary or appropriate for the protection of policyholders of the insurer; or  
1469           (ii) in the public interest.

1470       (3) The department may request:

1471           (a) (i) criminal background information maintained pursuant to Title 53, Chapter 10,  
1472 Part 2, from the Bureau of Criminal Identification; and

1473           (ii) complete Federal Bureau of Investigation criminal background checks through the  
1474 national criminal history system.

1475       (b) Information obtained by the department from the review of criminal history records  
1476 received under Subsection (3)(a) shall be used by the department for the purpose of:

1477           (i) verifying the information in Subsection (2)(a)(i);  
1478           (ii) determining the integrity of persons who would control the operation of an insurer;  
1479 and

1480           (iii) preventing persons who violate 18 U.S.C. Sections 1033 and 1034 from engaging  
1481 in the business of insurance in the state.

1482       (c) If the department requests the criminal background information, the department

1483 shall:

1484 (i) pay to the Department of Public Safety the costs incurred by the Department of  
1485 Public Safety in providing the department criminal background information under Subsection  
1486 (3)(a)(i);

1487 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau  
1488 of Investigation in providing the department criminal background information under  
1489 Subsection (3)(a)(ii); and

1490 (iii) charge the person required to file the statement referred to in Subsection (1) a fee  
1491 equal to the aggregate of Subsections (3)(c)(i) and (ii).

1492 (4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in  
1493 the lender's ordinary course of business, the identity of the lender shall remain confidential, if  
1494 the person filing the statement so requests.

1495 (b) (i) Under Subsection (2)(e), the commissioner may require a statement of the  
1496 adjusted book value assigned by the acquiring party to each security in arriving at the terms of  
1497 the offer[~~, with~~].

1498 (ii) For purposes of this Subsection (4)(b), "adjusted book value" [~~meaning~~] means  
1499 each security's proportional interest in the capital and surplus of the insurer with adjustments  
1500 that reflect:

1501 [(i)] (A) market conditions;

1502 [(ii)] (B) business in force; and

1503 [(iii)] (C) other intangible assets or liabilities of the insurer.

1504 (c) The description required by Subsection (2)(g) shall identify the persons with whom  
1505 the contracts, arrangements, or understandings have been entered into.

1506 (5) (a) If the person required to file the statement referred to in Subsection (1) is a  
1507 partnership, limited partnership, syndicate, or other group, the commissioner may require that  
1508 all the information called for by Subsections (2), (3), or (4) shall be given with respect to each:

1509 (i) partner of the partnership or limited partnership;

1510 (ii) member of the syndicate or group; and

1511 (iii) person who controls the partner or member.

1512 (b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation,  
1513 or if the person required to file the statement referred to in Subsection (1) is a corporation, the

1514 commissioner may require that the information called for by Subsection (2) shall be given with  
1515 respect to:

- 1516 (i) the corporation;
- 1517 (ii) each officer and director of the corporation; and
- 1518 (iii) each person who is directly or indirectly the beneficial owner of more than 10% of  
1519 the outstanding voting securities of the corporation.

1520 (6) If any material change occurs in the facts set forth in the statement filed with the  
1521 commissioner and sent to the insurer pursuant to Subsection (2), an amendment setting forth  
1522 the change, together with copies of all documents and other material relevant to the change,  
1523 shall be filed with the commissioner and sent to the insurer within two business days after the  
1524 filing person learns of such change.

1525 (7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection  
1526 (1) is proposed to be made by means of a registration statement under the Securities Act of  
1527 1933, or under circumstances requiring the disclosure of similar information under the  
1528 Securities Exchange Act of 1934, or under a state law requiring similar registration or  
1529 disclosure, a person required to file the statement referred to in Subsection (1) may use copies  
1530 of any registration or disclosure documents in furnishing the information called for by the  
1531 statement.

1532 (8) (a) The commissioner shall approve any merger or other acquisition of control  
1533 referred to in Subsection (1) unless, after a public hearing on the merger or acquisition, the  
1534 commissioner finds that:

1535 (i) after the change of control, the domestic insurer referred to in Subsection (1) would  
1536 not be able to satisfy the requirements for the issuance of a license to write the line or lines of  
1537 insurance for which it is presently licensed;

1538 (ii) the effect of the merger or other acquisition of control would:

1539 (A) substantially lessen competition in insurance in this state; or

1540 (B) tend to create a monopoly in insurance;

1541 (iii) the financial condition of any acquiring party might:

1542 (A) jeopardize the financial stability of the insurer; or

1543 (B) prejudice the interest of:

1544 (I) its policyholders; or

1545 (II) any remaining securityholders who are unaffiliated with the acquiring party;  
1546 (iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in  
1547 Subsection (1) are unfair and unreasonable to the securityholders of the insurer;  
1548 (v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its  
1549 assets, or consolidate or merge it with any person, or to make any other material change in its  
1550 business or corporate structure or management, are:  
1551 (A) unfair and unreasonable to policyholders of the insurer; and  
1552 (B) not in the public interest; or  
1553 (vi) the competence, experience, and integrity of those persons who would control the  
1554 operation of the insurer are such that it would not be in the interest of the policyholders of the  
1555 insurer and the public to permit the merger or other acquisition of control.  
1556 (b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not  
1557 be considered unfair if the adjusted book values under Subsection (2)(e):  
1558 (i) are disclosed to the securityholders; and  
1559 (ii) determined by the commissioner to be reasonable.  
1560 (9) (a) The public hearing referred to in Subsection (8) shall be held within 30 days  
1561 after the statement required by Subsection (1) is filed.  
1562 (b) (i) At least 20 days notice of the hearing shall be given by the commissioner to the  
1563 person filing the statement.  
1564 (ii) Affected parties may waive the notice required by this Subsection (9)(b).  
1565 (iii) Not less than seven days notice of the public hearing shall be given by the person  
1566 filing the statement to:  
1567 (A) the insurer; and  
1568 (B) any person designated by the commissioner.  
1569 (c) The commissioner shall make a determination within 30 days after the conclusion  
1570 of the hearing.  
1571 (d) At the hearing, the person filing the statement, the insurer, any person to whom  
1572 notice of hearing was sent, and any other person whose interest may be affected by the hearing  
1573 may:  
1574 (i) present evidence;  
1575 (ii) examine and cross-examine witnesses; and

1576 (iii) offer oral and written arguments.

1577 (e) (i) A person or insurer described in Subsection (9)(d) may conduct discovery  
1578 proceedings in the same manner as is presently allowed in the district courts of this state.

1579 (ii) All discovery proceedings shall be concluded not later than three days before the  
1580 commencement of the public hearing.

1581 ~~[(10) At the acquiring person's expense and consent, the commissioner may retain any~~  
1582 ~~attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's~~  
1583 ~~staff, which are reasonably necessary to assist the commissioner in reviewing the proposed~~  
1584 ~~acquisition of control.]~~

1585 (10) (a) The commissioner may retain technical experts to assist in reviewing all, or a  
1586 portion of, information filed in connection with a proposed merger or other acquisition of  
1587 control referred to in Subsection (1).

1588 (b) In determining whether any of the conditions in Subsection (8) exist, the  
1589 commissioner may consider the findings of technical experts employed to review applicable  
1590 filings.

1591 (c) (i) A technical expert employed under Subsection (10)(a) shall present to the  
1592 commissioner a statement of all expenses incurred by the technical expert in conjunction with  
1593 the technical expert's review of a proposed merger or other acquisition of control.

1594 (ii) At the commissioner's direction the acquiring person shall compensate the technical  
1595 expert at customary rates for time and expenses:

1596 (A) necessarily incurred; and

1597 (B) approved by the commissioner.

1598 (iii) The acquiring person shall:

1599 (A) certify the consolidated account of all charges and expenses incurred for the review  
1600 by technical experts;

1601 (B) retain a copy of the consolidated account described in Subsection (10)(c)(iii)(A);

1602 and

1603 (C) file with the department as a public record a copy of the consolidated account  
1604 described in Subsection (10)(c)(iii)(A).

1605 (11) (a) (i) If a domestic insurer proposes to merge into another insurer, any  
1606 securityholder electing to exercise a right of dissent may file with the insurer a written request

1607 for payment of the adjusted book value given in the statement required by Subsection (1) and  
1608 approved under Subsection (8), in return for the surrender of the security holder's securities.

1609 (ii) The request described in Subsection (11)(a)(i) shall be filed not later than ten days  
1610 after the day of the securityholders' meeting where the corporate action is approved.

1611 (b) The dissenting securityholder is entitled to and the insurer is required to pay to the  
1612 dissenting securityholder the specified value within 60 days of receipt of the dissenting security  
1613 holder's security.

1614 (c) Persons electing under this Subsection (11) to receive cash for their securities waive  
1615 the dissenting shareholder and appraisal rights otherwise applicable under Title 16, Chapter  
1616 10a, Part 13, Dissenters' Rights.

1617 (d) (i) This Subsection (11) provides an elective procedure for dissenting  
1618 securityholders to resolve their objections to the plan of merger.

1619 (ii) This section does not restrict the rights of dissenting securityholders under Title 16,  
1620 Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this  
1621 Subsection (11).

1622 (12) (a) All statements, amendments, or other material filed under Subsection (1), and  
1623 all notices of public hearings held under Subsection (8), shall be mailed by the insurer to its  
1624 securityholders within five business days after the insurer has received the statements,  
1625 amendments, other material, or notices.

1626 (b) (i) Mailing expenses shall be paid by the person making the filing.

1627 (ii) As security for the payment of ~~these~~ mailing expenses, that person shall file with  
1628 the commissioner an acceptable bond or other deposit in an amount determined by the  
1629 commissioner.

1630 (13) This section does not apply to any offer, request, invitation, agreement, or  
1631 acquisition that the commissioner by order exempts from the requirements of this section as:

1632 (a) not having been made or entered into for the purpose of, and not having the effect  
1633 of, changing or influencing the control of a domestic insurer; or

1634 (b) as otherwise not comprehended within the purposes of this section.

1635 (14) The following are violations of this section:

1636 (a) the failure to file any statement, amendment, or other material required to be filed  
1637 pursuant to Subsections (1), (2), and (5); or

1638 (b) the effectuation, or any attempt to effectuate, an acquisition of control of or merger  
1639 with a domestic insurer unless the commissioner has given the commissioner's approval to the  
1640 acquisition or merger.

1641 (15) (a) The courts of this state are vested with jurisdiction over:

1642 (i) a person who:

1643 (A) files a statement with the commissioner under this section; and

1644 (B) is not resident, domiciled, or authorized to do business in this state; and

1645 (ii) overall actions involving persons described in Subsection (15)(a)(i) arising out of a  
1646 violation of this section.

1647 (b) A person described in Subsection (15)(a) is considered to have performed acts  
1648 equivalent to and constituting an appointment of the commissioner by that person, to be that  
1649 person's lawful [attorney] agent upon whom may be served all lawful process in any action,  
1650 suit, or proceeding arising out of a violation of this section.

1651 (c) A copy of a lawful process described in Subsection (15)(b) shall be:

1652 (i) served on the commissioner; and

1653 (ii) transmitted by registered or certified mail by the commissioner to the person at that  
1654 person's last-known address.

1655 Section 8. Section 31A-21-110 is enacted to read:

1656 **31A-21-110. Prohibition against certain use of Social Security number --**

1657 **Exceptions -- Applicability of section.**

1658 (1) As used in this section "publicly display or publicly post" means to intentionally  
1659 communicate or otherwise make available to the general public.

1660 (2) An insurer not subject to Section 31A-22-634 may not do any of the following:

1661 (a) publicly display or publicly post in any manner an individual's Social Security  
1662 number; or

1663 (b) print an individual's Social Security number on any card required for the individual  
1664 to access products or services provided or covered by the insurer.

1665 (3) This section does not prevent:

1666 (a) the collection, use, or release of a Social Security number as required by state or  
1667 federal law;

1668 (b) the use of a Social Security number for internal verification or administrative

1669 purposes; or

1670 (c) the release of a Social Security number:

1671 (i) for claims administration purposes; or

1672 (ii) as part of the verification, eligibility, or payment process.

1673 (4) (a) An insurer shall comply with this section by July 1, 2005.

1674 (b) An insurer may obtain an extension for compliance with this section in accordance  
1675 with this Subsection (4)(b).

1676 (i) The request for extension shall:

1677 (A) be in writing to the department prior to July 1, 2005; and

1678 (B) provide an explanation as to why the insurer cannot comply.

1679 (ii) The commissioner shall grant a request for extension:

1680 (A) for a period of time not to exceed March 1, 2006; and

1681 (B) if the commissioner finds that the explanation provided under Subsection (4)(b)(i)  
1682 is a reasonable explanation.

1683 Section 9. Section **31A-23a-112** is amended to read:

1684 **31A-23a-112. Probation -- Grounds for revocation.**

1685 (1) The commissioner may place a licensee on probation for a period not to exceed 24  
1686 months as follows:

1687 (a) after an adjudicative proceeding under Title 63, Chapter 46b, Administrative  
1688 Procedures Act, for any circumstances that would justify a suspension under Section  
1689 31A-23a-111; or

1690 (b) at the issuance of a new license:

1691 (i) with an admitted violation under 18 U.S.C. Sections 1033 and 1034; or

1692 (ii) with a response to background information questions on any new license  
1693 application indicating that:

1694 (A) the person has been convicted of a crime, [~~as defined~~] that is listed by rule made in  
1695 accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, as a crime that is  
1696 grounds for probation;

1697 (B) the person is currently charged with a crime, [~~as defined~~] that is listed by rule made  
1698 in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, as a crime that  
1699 is grounds for probation regardless of whether adjudication was withheld;

1700 (C) the person has been involved in an administrative proceeding regarding any  
1701 professional or occupational license; or

1702 (D) any business in which the person is or was an owner, partner, officer, or director  
1703 has been involved in an administrative proceeding regarding any professional or occupational  
1704 license.

1705 (2) The commissioner may put a new licensee on probation for a specified period no  
1706 longer than 12 months if the licensee has admitted to violations under 18 U.S.C. Sections 1033  
1707 and 1034.

1708 (3) The probation order shall state the conditions for retention of the license, which  
1709 shall be reasonable.

1710 (4) Any violation of the probation is grounds for revocation pursuant to any proceeding  
1711 authorized under Title 63, Chapter 46b, Administrative Procedures Act.

1712 Section 10. Section **31A-23a-409** is amended to read:

1713 **31A-23a-409. Trust obligation for funds collected.**

1714 (1) (a) Every licensee is a trustee for all funds received or collected for forwarding to  
1715 insurers or to insureds.

1716 (b) Except for amounts necessary to pay bank charges, and except for funds paid by  
1717 insureds and belonging in part to the licensee as fees or commissions, a licensee may not  
1718 commingle trust funds with:

1719 (i) the licensee's own funds; or [~~with~~]

1720 (ii) funds held in any other capacity.

1721 (c) Except as provided under Subsection (4), every licensee owes to insureds and  
1722 insurers the fiduciary duties of a trustee with respect to money to be forwarded to insurers or  
1723 insureds through the licensee.

1724 (d) (i) Unless the funds are sent to the appropriate payee by the close of the next  
1725 business day after their receipt, the licensee shall deposit them in an account authorized under  
1726 Subsection (2).

1727 (ii) Funds [~~so~~] deposited under this Subsection (1)(d) shall remain in an account  
1728 authorized under Subsection (2) until sent to the appropriate payee.

1729 (2) Funds required to be deposited under Subsection (1) shall be deposited:

1730 (a) in a federally insured trust account [~~with a financial institution located in this state~~]

1731 in a depository institution, as defined in Section 7-1-103, which:

1732 (i) has an office in this state;

1733 (ii) has federal deposit insurance; and

1734 (iii) is authorized by its primary regulator to engage in the trust business, as defined by

1735 Section 7-5-1, in this state; or

1736 (b) in some other account, approved by the commissioner by rule or order, providing  
1737 safety comparable to federally insured trust accounts.

1738 (3) It is not a violation of Subsection (2)(a) if the amounts in the accounts exceed the  
1739 amount of the federal insurance on the accounts.

1740 (4) A trust account into which funds are deposited may be interest bearing. The  
1741 interest accrued on the account may be paid to the licensee, so long as the licensee otherwise  
1742 complies with this section and with the contract with the insurer.

1743 (5) A financial institution or other organization holding trust funds under this section  
1744 may not offset or impound trust account funds against debts and obligations incurred by the  
1745 licensee.

1746 (6) Any licensee who, not being lawfully entitled thereto, diverts or appropriates any  
1747 portion of the funds held under Subsection (1) to the licensee's own use, is guilty of theft under  
1748 Title 76, Chapter 6, Part 4. Section 76-6-412 applies in determining the classification of the  
1749 offense. Sanctions under Section 31A-2-308 also apply.

1750 Section 11. Section **31A-29-103** is amended to read:

1751 **31A-29-103. Definitions.**

1752 As used in this chapter:

1753 (1) "Board" means the board of directors of the pool created in Section 31A-29-104.

1754 (2) (a) "Creditable coverage" has the same meaning as provided in the Health Insurance  
1755 Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat.1956, Sec. 2701(c)(1) and 45  
1756 C.F.R. Sec. 146.11(a)(1)[;].

1757 (b) "Creditable coverage" does not include a period of time in which there is a  
1758 significant break in coverage as described in the Health Insurance Portability and  
1759 Accountability Act, Pub. L. No. 104-191, 110 Stat. 1956, Sec. 2701(c)(2).

1760 (3) "Domicile" means the place where an individual has a fixed and permanent home  
1761 and principal establishment:

1762           (a) to which the individual, if absent, intends to return; and  
1763           (b) in which the individual, and the individual's family voluntarily reside, not for a  
1764 special or temporary purpose, but with the intention of making a permanent home.  
1765           ~~[(3)]~~ (4) "Enrollee" means an individual who has met the eligibility requirements of the  
1766 pool and is covered by a pool policy under this chapter.  
1767           ~~[(4)]~~ (5) "Health care facility" means any entity providing health care services which is  
1768 licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.  
1769           ~~[(5)]~~ (6) "Health care provider" has the same meaning as provided in Section 78-14-3.  
1770           ~~[(6)]~~ (7) "Health care services" means:  
1771           (a) any service or product;  
1772           (i) used in furnishing to any individual medical care or hospitalization[;]; or  
1773           (ii) incidental to furnishing medical care or hospitalization[;]; and  
1774           (b) any other service or product furnished for the purpose of preventing, alleviating,  
1775 curing, or healing human illness or injury.  
1776           ~~[(7)]~~ (8) (a) "Health insurance" means any:  
1777           (i) hospital and medical expense-incurred policy;  
1778           (ii) nonprofit health care service plan contract; or  
1779           (iii) health maintenance organization subscriber contract.  
1780           (b) "Health insurance" does not mean:  
1781           (i) any insurance arising out of [~~the Workers' Compensation Act~~] Title 34A, Chapter 2  
1782 or 3, or similar law;  
1783           (ii) automobile medical payment insurance; or  
1784           (iii) insurance under which benefits are payable with or without regard to fault and  
1785 which is required by law to be contained in any liability insurance policy.  
1786           ~~[(8)]~~ (9) "Health maintenance organization" has the same meaning as provided in  
1787 Section 31A-8-101.  
1788           ~~[(9)]~~ (10) (a) "Health plan" means any arrangement by which an individual, including a  
1789 dependent or spouse, covered or making application to be covered under the pool has:  
1790           (i) access to hospital and medical benefits or reimbursement including group or  
1791 individual insurance or subscriber contract;  
1792           (ii) coverage through;

- 1793            (A) a health maintenance organization[;];
- 1794            (B) a preferred provider prepayment[;];
- 1795            (C) group practice[;]; or
- 1796            (D) individual practice plan;
- 1797            (iii) coverage under an uninsured arrangement of group or group-type contracts
- 1798 including employer self-insured, cost-plus, or other benefits methodologies not involving
- 1799 insurance;
- 1800            (iv) coverage under a group type contract which is not available to the general public
- 1801 and can be obtained only because of connection with a particular organization or group; and
- 1802            (v) coverage by Medicare or other governmental benefit. [~~The term~~]
- 1803            (b) "Health plan" includes coverage through health insurance.
- 1804            [~~(10)~~] (11) "HIPAA" means the Health Insurance Portability and Accountability Act,
- 1805 Pub. L. No. 104-191, 110 Stat.1962.
- 1806            [~~(11)~~] (12) "HIPAA eligible" means an individual who is eligible under the provisions
- 1807 of the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat.
- 1808 1979, Sec. 2741(b).
- 1809            [~~(12)~~] (13) "Insurer" means;
- 1810            (a) an insurance company authorized to transact accident and health insurance business
- 1811 in this state[;];
- 1812            (b) a health maintenance organization[;]; and
- 1813            (c) a self-insurer not subject to federal preemption.
- 1814            [~~(13)~~] (14) "Medicaid" means coverage under Title XIX of the Social Security Act, 42
- 1815 U.S.C. Sec. 1396 et seq., as amended.
- 1816            [~~(14)~~] (15) "Medicare" means coverage under both Part A and B of Title XVIII of the
- 1817 Social Security Act, 42 U.S.C. 1395 et seq., as amended.
- 1818            [~~(15)~~] (16) "Plan of operation" means the plan developed by the board in accordance
- 1819 with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the
- 1820 board under Section 31A-29-106.
- 1821            [~~(16)~~] (17) "Pool" means the Utah Comprehensive Health Insurance Pool created in
- 1822 Section 31A-29-104.
- 1823            [~~(17)~~] (18) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise

1824 Fund created in Section 31A-29-120.

1825 ~~[(18)]~~ (19) "Pool policy" means a health insurance policy issued under this chapter.

1826 ~~[(19)]~~ (20) "Preexisting condition" means a condition, regardless of the cause of the  
1827 condition, for which medical advice, diagnosis, care, or treatment was recommended or  
1828 received within the six-month period immediately prior to the enrollment date.

1829 ~~[(20)]~~ (21) (a) "Resident" or "residency" means ~~[an individual]~~ a person who is  
1830 domiciled in this state ~~[as defined in Section 23-13-2]~~.

1831 (b) A resident retains residency if that resident leaves this state:

1832 (i) to serve in the armed forces of the United States; or

1833 (ii) for religious or educational purposes.

1834 ~~[(21)]~~ (22) "Third-party administrator" has the same meaning as provided in Section  
1835 31A-1-301.

1836 Section 12. Section **31A-29-104** is amended to read:

1837 **31A-29-104. Creation of pool -- Board of directors -- Appointment -- Terms --**  
1838 **Quorum -- Plan preparation.**

1839 (1) There is created the "Utah Comprehensive Health Insurance Pool," a nonprofit  
1840 entity within the Insurance Department.

1841 (2) The pool shall be under the direction of a board of directors composed of ~~[(11)]~~ 12  
1842 members.

1843 (a) The governor shall appoint ten of the directors with the consent of the Senate as  
1844 follows:

1845 (i) two representatives of health insurance companies or health service organizations;

1846 (ii) one representative of a health maintenance organization;

1847 (iii) one physician;

1848 (iv) one representative of hospitals;

1849 (v) one representative of the general public who is reasonably expected to qualify for  
1850 coverage under the pool;

1851 (vi) one parent or spouse of such an individual;

1852 (vii) one representative of the general public; ~~[and]~~

1853 (viii) one representative of employers~~[-];~~ and

1854 (ix) one licensed producer with an accident and health line of authority.

1855 (b) The board shall also include:

1856 (i) the commissioner or ~~his~~ the commissioner's designee; and

1857 (ii) the executive director of the Department of Health or ~~his~~ the executive director's  
1858 designee.

1859 (3) (a) Except as required by Subsection (3)(b), as terms of current board members  
1860 expire, the governor shall appoint each new member or reappointed member to a four-year  
1861 term.

1862 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the  
1863 time of appointment or reappointment, adjust the length of terms to ensure that the terms of  
1864 board members are staggered so that approximately half of the board is appointed every two  
1865 years.

1866 (4) When a vacancy occurs in the membership for any reason, the replacement shall be  
1867 appointed for the unexpired term in the same manner as the original appointment was made.

1868 (5) (a) (i) Members who are not government employees shall receive no compensation  
1869 or benefits for their services, but may receive per diem and expenses incurred in the  
1870 performance of the member's official duties at the rates established by the Division of Finance  
1871 under Sections 63A-3-106 and 63A-3-107 from the Pool Fund.

1872 (ii) Members may decline to receive per diem and expenses for their service.

1873 (b) (i) State government officer and employee members who do not receive salary, per  
1874 diem, or expenses from their agency for their service may receive per diem and expenses  
1875 incurred in the performance of their official duties from the pool at the rates established by the  
1876 Division of Finance under Sections 63A-3-106 and 63A-3-107.

1877 (ii) A state government member who is a member because of their state government  
1878 position may not receive per diem or expenses for their service.

1879 (iii) State government officer and employee members may decline to receive per diem  
1880 and expenses for their service.

1881 (6) The board shall elect annually a chair and vice chair from its membership.

1882 (7) Six board members are a quorum for the transaction of business.

1883 (8) The action of a majority of the members of the quorum is the action of the board.

1884 (9) The board shall submit a plan of operation to the commissioner no later than  
1885 January 1, 1991.

1886 (10) The sale of policies under this chapter shall commence on July 1, 1991, or as soon  
1887 thereafter as adequate funding for the coverage is available as determined by the commissioner.

1888 Section 13. Section **31A-29-111** is amended to read:

1889 **31A-29-111. Eligibility -- Limitations.**

1890 (1) (a) Except as provided in ~~Subsection~~ Subsections (1)(b) and (2), an individual  
1891 who is not HIPAA eligible is eligible for pool coverage if the individual:

1892 (i) pays the established premium;

1893 (ii) is a resident of this state; and

1894 (iii) meets the health underwriting criteria under Subsection ~~[(4)]~~ (5)(a).

1895 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not  
1896 eligible for pool coverage if one or more of the following conditions apply:

1897 (i) ~~[at the time of application,]~~ the individual is eligible for health care benefits under  
1898 Medicaid or Medicare, except as provided in Section 31A-29-112;

1899 (ii) the individual has terminated coverage in the pool, unless:

1900 (A) 12 months have elapsed since the termination date; or

1901 (B) the individual demonstrates that creditable coverage has been involuntarily  
1902 terminated for any reason other than nonpayment of premium;

1903 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

1904 (iv) the individual is an inmate of a public institution;

1905 (v) the individual is eligible for other public programs for which medical care is  
1906 provided;

1907 (vi) the individual's health condition does not meet the criteria established under  
1908 Subsection ~~[(4)]~~ (5);

1909 (vii) the individual is ~~[an eligible employee, a dependent of an eligible employee, or a~~  
1910 ~~member of]~~ eligible for coverage under an employer group that offers health insurance or a  
1911 self-insurance arrangement to [at] its eligible employees, dependents, or members[;] as:

1912 (A) an eligible employee;

1913 (B) a dependent of an eligible employee; or

1914 (C) a member;

1915 (viii) ~~[at the time the pool coverage is applied for,]~~ the individual:

1916 (A) has coverage substantially equivalent to a pool policy, as established by the board

1917 in administrative rule, either as an insured or a covered dependent~~[-];~~ or ~~[the individual]~~  
 1918 (B) would be eligible for the substantially equivalent coverage if the individual elected  
 1919 to obtain the coverage; or

1920 (ix) at the time of application, the individual~~[-(A) is not HIPAA eligible; and (B)]~~ has  
 1921 not resided in Utah for at least 12 consecutive months preceding the date of application.

1922 (2) (a) Except as provided in Subsections (1) and (2)(b), an individual who is HIPAA  
 1923 eligible is eligible for pool coverage if the individual:

1924 (i) pays the established premium; and

1925 (ii) is a resident of this state.

1926 (b) Notwithstanding Subsections (1) and (2)(a), a HIPAA eligible individual is not  
 1927 eligible for pool coverage if one or more of the following conditions apply:

1928 (i) the individual is eligible for health care benefits under Medicaid or Medicare,  
 1929 except as provided in Section 31A-29-112;

1930 (ii) the individual is eligible for other public programs for which medical care is  
 1931 provided;

1932 (iii) the individual is covered under any other health insurance;

1933 (iv) the individual is eligible for coverage under an employer group that offers health  
 1934 insurance or self insurance arrangements to its eligible employees, dependents, or members as:

1935 (A) an eligible employee;

1936 (B) a dependent of an eligible employee; or

1937 (C) a member;

1938 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual; or

1939 (vi) the individual is an inmate of a public institution.

1940 ~~[(2)]~~ (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under  
 1941 Subsection (1)(a), an individual whose health insurance coverage from a state ~~[health]~~ high risk  
 1942 pool with similar coverage is terminated because of nonresidency in another state may apply  
 1943 for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through ~~[(vii)]~~  
 1944 (viii).

1945 (b) [(i)] Coverage sought under Subsection ~~[(2)]~~ (3)(a) shall be applied for within 63  
 1946 days after the termination date of the previous high risk pool coverage.

1947 ~~[(i)]~~ (c) ~~[If premiums are paid for the entire coverage period under the previous risk~~

1948 ~~pool with similar coverage, the]~~ The effective date of this state's pool coverage shall be the date  
1949 of termination of the previous high risk pool coverage.

1950 ~~[(iii) If premiums are not paid back to the previous risk pool termination date, then the~~  
1951 ~~effective date will be determined by the pool administrator in accordance with the date of~~  
1952 ~~application.]~~

1953 ~~[(c)]~~ (d) The waiting period of an individual with a preexisting condition applying for  
1954 coverage under this chapter shall be waived:

1955 (i) to the extent to which the waiting period was satisfied under a similar plan from  
1956 another state; and

1957 (ii) if the other state's benefit limitation was not reached.

1958 ~~[(3)]~~ (4) (a) If an eligible individual applies for pool coverage within 30 days of being  
1959 denied coverage by an individual carrier, the effective date for pool coverage shall be no later  
1960 than the first day of the month following the date of submission of the completed insurance  
1961 application to the carrier.

1962 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under  
1963 Subsection (3), the effective date shall be the date of termination of the previous high risk pool  
1964 coverage.

1965 ~~[(4)]~~ (5) (a) The board shall establish and adjust, as necessary, health underwriting  
1966 criteria based on:

1967 (i) health condition; and

1968 (ii) expected claims so that the expected claims are anticipated to remain within  
1969 available funding.

1970 (b) The board, with approval of the commissioner, may contract with one or more  
1971 providers under Title 63, Chapter 56, Utah Procurement Code, to develop underwriting criteria  
1972 under Subsection ~~[(4)]~~ (5)(a).

1973 (c) If an individual is denied coverage by the pool under the criteria established in  
1974 Subsection ~~[(4)]~~ (5)(a), the pool shall issue a certificate of insurability to the individual for  
1975 coverage under Subsection 31A-30-108(3).

1976 Section 14. Section **31A-29-112** is amended to read:

1977 **31A-29-112. Medicaid recipients.**

1978 (1) If authorized by federal statutes or rules, an individual receiving Medicaid benefits

1979 may continue to receive those benefits while satisfying the preexisting condition requirements  
1980 established by Section 31A-29-113 and the terms of the pool policy issued under this chapter.

1981 (2) If allowed by federal statute, federal regulation, state statute, or rule, the  
1982 Department of Health shall allocate premiums paid to the pool by an individual receiving  
1983 Medicaid benefits to that individual's spenddown for purposes of the Medicaid program.

1984 (3) (a) If an individual continues to receive Medicaid benefits after the requirements for  
1985 a preexisting condition are satisfied, the pool administrator may not issue a pool policy or  
1986 allow that individual to receive any benefit from the pool.

1987 (b) If an individual continues to receive Medicaid benefits when the requirements for a  
1988 preexisting condition are satisfied, the pool administrator shall give any premiums collected by  
1989 it during the preexisting conditions period to the Medicaid program.

1990 (4) (a) If an enrollee becomes eligible to receive Medicaid benefits, the enrollee's  
1991 coverage by the pool terminates as of the effective date of Medicaid coverage.

1992 (b) The pool administrator shall:

1993 (i) include a provision in the pool policy requiring an enrollee to provide written notice  
1994 to the pool administration if the enrollee becomes covered by Medicaid; and

1995 (ii) terminate an enrollee's coverage by the pool as of the effective date of the enrollee's  
1996 Medicaid coverage when the pool administrator becomes aware that the enrollee is covered by  
1997 Medicaid.

1998 (5) If an individual terminates coverage under Medicaid and applies for coverage under  
1999 a pool policy within 45 days after terminating the coverage, the individual may begin coverage  
2000 under a pool policy as of the date that Medicaid coverage terminated, if an individual meets the  
2001 other eligibility requirements of the chapter and pays the required premium.

2002 (6) Notwithstanding [~~the provision of Subsection~~] Subsections 31A-29-111(1)(b)(i)  
2003 and (2)(b)(i), an individual is eligible for coverage by the pool if the requirements of Section  
2004 31A-29-111 are met and if:

2005 (a) the individual's eligibility for Medicaid requires a spenddown, as defined by rule,  
2006 that exceeds the premium for a pool policy; or

2007 (b) the individual is eligible for the Primary Care Network program administered by  
2008 the Department of Health.

2009 Section 15. Section **31A-29-113** is amended to read:

2010           **31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting**  
2011 **conditions -- Waiver -- Maximum benefits.**

2012           (1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished  
2013 for the diagnoses or treatment of illness or injury that:

2014           (i) exceed the deductible and copayment amounts applicable under Section  
2015 31A-29-114; and

2016           (ii) are not otherwise limited or excluded.

2017           (b) Eligible medical expenses are the allowed charges established by the board for the  
2018 health care services and items rendered during times for which benefits are extended under the  
2019 pool policy.

2020           (2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and  
2021 other limitations shall be established by the board.

2022           (3) The commissioner shall approve the benefit package developed by the board to  
2023 ensure its compliance with this chapter.

2024           (4) The pool shall offer at least one benefit plan through a managed care program as  
2025 authorized under Section 31A-29-106.

2026           (5) This chapter may not be construed to prohibit the pool from issuing additional types  
2027 of pool policies with different types of benefits which in the opinion of the board may be of  
2028 benefit to the citizens of Utah.

2029           (6) (a) The board shall design and require an administrator to employ cost containment  
2030 measures and requirements including preadmission certification and concurrent inpatient  
2031 review for the purpose of making the pool more cost effective. [~~The provisions of]~~

2032           (b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this  
2033 chapter.

2034           (7) (a) A pool policy may contain provisions under which coverage for a preexisting  
2035 condition is excluded during a six-month period following the effective date of plan coverage  
2036 for a given individual.

2037           (b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

2038           (8) (a) A pool policy may [~~exclude coverage for pregnancies for ten months following~~  
2039 ~~the effective date of coverage, unless the individual is HIPAA eligible]~~ contain provisions  
2040 under which coverage for a preexisting pregnancy is excluded during a ten-month period

2041 following the effective date of plan coverage for a given individual.

2042 (b) Subsection (8)(a) does not apply to a HIPAA eligible individual.

2043 (9) (a) The pool will waive the preexisting condition exclusion described in

2044 ~~[Subsection]~~ Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to

2045 the pool, to the extent to which similar exclusions have been satisfied under any prior health

2046 insurance coverage if:

2047 (i) the individual applies not later than 63 days following the date of involuntary  
2048 termination, other than for nonpayment of premiums, from health coverage; or

2049 (ii) the individual's premium rate exceeds the rate of the pool for equal or lesser  
2050 coverage provided that the application for pool coverage is made no later than 63 days  
2051 following the termination from the prior health insurance coverage.

2052 ~~[(b) In accordance with Subsections (7)(b) and (8), the pool may not apply a  
2053 preexisting condition exclusion if the individual is HIPAA eligible.]~~

2054 ~~[(c)]~~ (b) If this Subsection (9) applies, coverage in the pool shall be effective from the  
2055 date on which the prior coverage was terminated.

2056 (10) Covered benefits available from the pool may not exceed a \$1,000,000 lifetime  
2057 maximum, which includes a per enrollee calendar year maximum established by the board.

2058 Section 16. Section **31A-29-114** is amended to read:

2059 **31A-29-114. Deductibles -- Copayments.**

2060 (1) (a) ~~[Subject to the limits provided in Subsection (3), a]~~ A pool policy shall impose  
2061 a deductible on a per calendar year basis.

2062 (b) ~~[Deductible]~~ At least two deductible plans ~~[of \$500 and \$1,000]~~ shall ~~[initially]~~ be  
2063 offered. ~~[Other higher deductible plans may be offered by the pool.]~~

2064 (c) The deductible is applied to all of the eligible medical expenses as defined in  
2065 Section 31A-29-113, incurred by the enrollee until the deductible has been satisfied. There are  
2066 no benefits payable before the deductible has been satisfied.

2067 (d) The pool may offer separate deductibles for prescription benefits.

2068 (2) (a) ~~[Subject to the limits provided in Subsection (3), a]~~ A mandatory coinsurance  
2069 requirement shall be imposed at the rate of at least 20% of eligible medical expenses in excess  
2070 of the mandatory deductible.

2071 (b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool

2072 policy.

2073 (3) ~~[Except as provided in Subsection (4), the]~~ The board shall establish maximum  
2074 aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee [in the  
2075 form of deductibles and coinsurance may not exceed:] for each of the deductible plans offered  
2076 under Subsection (1)(b).

2077 ~~[(a) \$1,500 per individual per calendar year for the \$500 deductible plan;]~~

2078 ~~[(b) \$2,000 per individual per calendar year for the \$1,000 deductible plan; or]~~

2079 ~~[(c) if other deductible plans are offered by the pool, an amount per individual will be~~  
2080 ~~established by the board.]~~

2081 (4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments  
2082 under Subsection (3), the board may establish a coinsurance requirement to be imposed on  
2083 eligible medical expenses in excess of the maximum aggregate out-of-pocket expense [~~limits~~  
2084 ~~set forth in Subsection (3)].~~

2085 (b) The circumstances in which the coinsurance authorized by this Subsection (4) may  
2086 be imposed shall be designated in the pool policy.

2087 (c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to  
2088 exceed 5% of eligible medical expenses.

2089 (5) The limits on maximum aggregate out-of-pocket payments for eligible medical  
2090 expenses incurred by the enrollee [~~in the form of deductibles and coinsurance]~~ under this  
2091 section shall not include out-of-pocket payments for prescription benefits.

2092 Section 17. Section **31A-29-115** is amended to read:

2093 **31A-29-115. Cancellation -- Notice.**

2094 (1) (a) On the date of renewal, the pool may cancel an enrollee's policy if:

2095 (i) the enrollee's health condition does not meet the criteria established in Subsection  
2096 31A-29-111[~~(4)~~](5);

2097 (ii) the pool has provided written notice to the enrollee's last-known address no less  
2098 than 60 days before cancellation; and

2099 (iii) at least one individual carrier has not reached the individual enrollment cap  
2100 established in Section 31A-30-110.

2101 (b) The pool shall issue a certificate of insurability to an enrollee whose policy is  
2102 cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the

2103 requirements of Subsection 31A-29-111[~~(4)~~](5) are met.

2104 (2) The pool may cancel an enrollee's policy at any time if:

2105 (a) the pool has provided written notice to the enrollee's last-known address no less  
2106 than 15 days before cancellation; and

2107 (b) (i) the enrollee establishes a residency outside of Utah for three consecutive  
2108 months;

2109 (ii) there is nonpayment of premiums; or

2110 (iii) the pool determines that the enrollee does not meet the eligibility requirements set  
2111 forth in Section 31A-29-111, in which case:

2112 (A) the policy may be retroactively terminated for the period of time in which the  
2113 enrollee was not eligible;

2114 (B) retroactive termination may not exceed three years; and

2115 (C) the board's remedy under this Subsection (2)(b) shall be a cause of action against  
2116 the enrollee for benefits paid during the period of ineligibility in accordance with Subsection  
2117 31A-29-119(3).

2118 Section 18. Section **31A-30-103** is amended to read:

2119 **31A-30-103. Definitions.**

2120 As used in this chapter:

2121 (1) "Actuarial certification" means a written statement by a member of the American  
2122 Academy of Actuaries or other individual approved by the commissioner that a covered carrier  
2123 is in compliance with Section 31A-30-106, based upon the examination of the covered carrier,  
2124 including review of the appropriate records and of the actuarial assumptions and methods used  
2125 by the covered carrier in establishing premium rates for applicable health benefit plans.

2126 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly  
2127 through one or more intermediaries, controls or is controlled by, or is under common control  
2128 with, a specified entity or person.

2129 (3) "Base premium rate" means, for each class of business as to a rating period, the  
2130 lowest premium rate charged or that could have been charged under a rating system for that  
2131 class of business by the covered carrier to covered insureds with similar case characteristics for  
2132 health benefit plans with the same or similar coverage.

2133 (4) "Basic coverage" means the coverage provided in the Basic Health Care Plan under

2134 Subsection 31A-22-613.5(2).

2135 (5) "Carrier" means any person or entity that provides health insurance in this state

2136 including:

2137 (a) an insurance company;

2138 (b) a prepaid hospital or medical care plan;

2139 (c) a health maintenance organization;

2140 (d) a multiple employer welfare arrangement; and

2141 (e) any other person or entity providing a health insurance plan under this title.

2142 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means

2143 demographic or other objective characteristics of a covered insured that are considered by the

2144 carrier in determining premium rates for the covered insured.

2145 (b) "Case characteristics" does not include:

2146 (i) duration of coverage since the policy was issued;

2147 (ii) claim experience; and

2148 (iii) health status.

2149 (7) "Class of business" means all or a separate grouping of covered insureds

2150 established under Section 31A-30-105.

2151 (8) "Conversion policy" means a policy providing coverage under the conversion

2152 provisions required in Chapter 22, Part VII, Group Accident and Health Insurance.

2153 (9) "Covered carrier" means any individual carrier or small employer carrier subject to

2154 this chapter.

2155 (10) "Covered individual" means any individual who is covered under a health benefit

2156 plan subject to this chapter.

2157 (11) "Covered insureds" means small employers and individuals who are issued a

2158 health benefit plan that is subject to this chapter.

2159 (12) "Dependent" means an individual to the extent that the individual is defined to be

2160 a dependent by:

2161 (a) the health benefit plan covering the covered individual; and

2162 (b) Chapter 22, Part VI, Accident and Health Insurance.

2163 (13) "Established geographic service area" means a geographical area approved by the

2164 commissioner within which the carrier is authorized to provide coverage.

2165 (14) "Index rate" means, for each class of business as to a rating period for covered  
2166 insureds with similar case characteristics, the arithmetic average of the applicable base  
2167 premium rate and the corresponding highest premium rate.

2168 (15) "Individual carrier" means a carrier that provides coverage on an individual basis  
2169 through a health benefit plan regardless of whether:

2170 (a) coverage is offered through:

2171 (i) an association;

2172 (ii) a trust;

2173 (iii) a discretionary group; or

2174 (iv) other similar groups; or

2175 (b) the policy or contract is situated out-of-state.

2176 (16) "Individual conversion policy" means a conversion policy issued to:

2177 (a) an individual; or

2178 (b) an individual with a family.

2179 (17) "Individual coverage count" means the number of natural persons covered under a  
2180 carrier's health benefit products that are individual policies.

2181 (18) "Individual enrollment cap" means the percentage set by the commissioner in  
2182 accordance with Section 31A-30-110.

2183 (19) "New business premium rate" means, for each class of business as to a rating  
2184 period, the lowest premium rate charged or offered, or that could have been charged or offered,  
2185 by the carrier to covered insureds with similar case characteristics for newly issued health  
2186 benefit plans with the same or similar coverage.

2187 (20) "Preexisting condition" is as defined in Section 31A-1-301.

2188 (21) "Premium" means all monies paid by covered insureds and covered individuals as  
2189 a condition of receiving coverage from a covered carrier, including any fees or other  
2190 contributions associated with the health benefit plan.

2191 (22) (a) "Rating period" means the calendar period for which premium rates  
2192 established by a covered carrier are assumed to be in effect, as determined by the carrier.

2193 (b) A covered carrier may not have:

2194 (i) more than one rating period in any calendar month; and

2195 (ii) no more than 12 rating periods in any calendar year.

2196 (23) "Resident" means an individual who has resided in this state for at least 12  
2197 consecutive months immediately preceding the date of application.

2198 (24) "Short-term limited duration insurance" means a health benefit product that:

2199 (a) is not renewable; and

2200 (b) has an expiration date specified in the contract that is less than 364 days after the  
2201 date the plan became effective.

2202 (25) "Small employer carrier" means a carrier that provides health benefit plans  
2203 covering eligible employees of one or more small employers in this state, regardless of  
2204 whether:

2205 (a) coverage is offered through:

2206 (i) an association;

2207 (ii) a trust;

2208 (iii) a discretionary group; or

2209 (iv) other similar grouping; or

2210 (b) the policy or contract is situated out-of-state.

2211 (26) "Uninsurable" means an individual who:

2212 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the  
2213 underwriting criteria established in Subsection 31A-29-111~~(4)~~(5); or

2214 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

2215 (ii) has a condition of health that does not meet consistently applied underwriting  
2216 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)  
2217 and (j) for which coverage the applicant is applying.

2218 (27) "Uninsurable percentage" for a given calendar year equals UC/CI where, for  
2219 purposes of this formula:

2220 (a) "UC" means the number of uninsurable individuals who were issued an individual  
2221 policy on or after July 1, 1997; and

2222 (b) "CI" means the carrier's individual coverage count as of December 31 of the  
2223 preceding year.

2224 Section 19. Section **31A-30-108** is amended to read:

2225 **31A-30-108. Eligibility for small employer and individual market.**

2226 (1) (a) Small employer carriers shall accept residents for small group coverage as set

2227 forth in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1962,  
2228 Sec. 2701(f) and 2711(a).

2229 (b) Individual carriers shall accept residents for individual coverage pursuant:

2230 (i) to P.L. 104-191, 110 Stat. 1979, Sec. 2741(a)-(b); and

2231 (ii) Subsection (3).

2232 (2) (a) Small employer carriers shall offer to accept all eligible employees and their  
2233 dependents at the same level of benefits under any health benefit plan provided to a small  
2234 employer.

2235 (b) Small employer carriers may:

2236 (i) request a small employer to submit a copy of the small employer's quarterly income  
2237 tax withholdings to determine whether the employees for whom coverage is provided or  
2238 requested are bona fide employees of the small employer; and

2239 (ii) deny or terminate coverage if the small employer refuses to provide documentation  
2240 requested under Subsection (2)(b)(i).

2241 (3) Except as provided in Subsection (5) and Section 31A-30-110, individual carriers  
2242 shall accept for coverage individuals to whom all of the following conditions apply:

2243 (a) the individual is not covered or eligible for coverage:

2244 (i) (A) as an employee of an employer;

2245 (B) as a member of an association; or

2246 (C) as a member of any other group; and

2247 (ii) under:

2248 (A) a health benefit plan; or

2249 (B) a self-insured arrangement that provides coverage similar to that provided by a  
2250 health benefit plan as defined in Section 31A-1-301;

2251 (b) the individual is not covered and is not eligible for coverage under any public  
2252 health benefits arrangement including:

2253 (i) the Medicare program established under Title XVIII of the Social Security Act;

2254 (ii) the Medicaid program established under Title XIX of the Social Security Act;

2255 (iii) any act of Congress or law of this or any other state that provides benefits  
2256 comparable to the benefits provided under this chapter; or

2257 (iv) coverage under the Comprehensive Health Insurance Pool Act created in Chapter

2258 29, Comprehensive Health Insurance Pool Act;

2259 (c) unless the maximum benefit has been reached the individual is not covered or

2260 eligible for coverage under any:

2261 (i) Medicare supplement policy;

2262 (ii) conversion option;

2263 (iii) continuation or extension under COBRA; or

2264 (iv) state extension;

2265 (d) the individual has not terminated or declined coverage described in Subsection

2266 (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for

2267 individual coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the

2268 requirement of this Subsection (3)(d) does not apply; and

2269 (e) the individual is certified as ineligible for the Health Insurance Pool if:

2270 (i) the individual applies for coverage with the Comprehensive Health Insurance Pool

2271 within 30 days after being rejected or refused coverage by the covered carrier and reapplies for

2272 coverage with that covered carrier within 30 days after the date of issuance of a certificate

2273 under Subsection 31A-29-111[~~(4)~~](5)(c); or

2274 (ii) the individual applies for coverage with any individual carrier within 45 days after:

2275 (A) notice of cancellation of coverage under Subsection 31A-29-115(1); or

2276 (B) the date of issuance of a certificate under Subsection 31A-29-111[~~(4)~~](5)(c) if the

2277 individual applied first for coverage with the Comprehensive Health Insurance Pool.

2278 (4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is

2279 paid, the effective date of coverage shall be the first day of the month following the individual's

2280 submission of a completed insurance application to that covered carrier.

2281 (b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is

2282 paid, the effective date of coverage shall be the day following the:

2283 (i) cancellation of coverage under Subsection 31A-29-115(1); or

2284 (ii) submission of a completed insurance application to the Comprehensive Health

2285 Insurance Pool.

2286 (5) (a) An individual carrier is not required to accept individuals for coverage under

2287 Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

2288 (b) A carrier described in Subsection (5)(a) may not issue new individual policies in

2289 the state for five years from July 1, 1997.

2290 (c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new  
2291 policies after July 1, 1999, which may only be granted if:

2292 (i) the carrier accepts uninsurables as is required of a carrier entering the market under  
2293 Subsection 31A-30-110; and

2294 (ii) the commissioner finds that the carrier's issuance of new individual policies:

2295 (A) is in the best interests of the state; and

2296 (B) does not provide an unfair advantage to the carrier.

2297 (6) (a) If a small employer carrier offers health benefit plans to small employers  
2298 through a network plan, the small employer carrier may:

2299 (i) limit the employers that may apply for the coverage to those employers with eligible  
2300 employees who live, reside, or work in the service area for the network plan; and

2301 (ii) within the service area of the network plan, deny coverage to an employer if the  
2302 small employer carrier has demonstrated to the commissioner that the small employer carrier:

2303 (A) will not have the capacity to deliver services adequately to enrollees of any  
2304 additional groups because of the small employer carrier's obligations to existing group contract  
2305 holders and enrollees; and

2306 (B) applies this section uniformly to all employers without regard to:

2307 (I) the claims experience of an employer, an employer's employee, or a dependent of an  
2308 employee; or

2309 (II) any health status-related factor relating to an employee or dependent of an  
2310 employee.

2311 (b) (i) A small employer carrier that denies a health benefit product to an employer in  
2312 any service area in accordance with this section may not offer coverage in the small employer  
2313 market within the service area to any employer for a period of 180 days after the date the  
2314 coverage is denied.

2315 (ii) This Subsection (6)(b) does not:

2316 (A) limit the small employer carrier's ability to renew coverage that is in force; or

2317 (B) relieve the small employer carrier of the responsibility to renew coverage that is in  
2318 force.

2319 (c) Coverage offered within a service area after the 180-day period specified in

2320 Subsection (6)(b) is subject to the requirements of this section.

2321 Section 20. Section **31A-38-101** is enacted to read:

2322 **CHAPTER 38. FEDERAL HEALTH CARE TAX CREDIT PROGRAM ACT**

2323 **31A-38-101. Title.**

2324 This chapter is known as the "Federal Health Care Tax Credit Program Act."

2325 Section 21. Section **31A-38-102** is enacted to read:

2326 **31A-38-102. Definitions.**

2327 As used in this chapter:

2328 (1) "Bridge program" means the program established by the Department of Workforce  
2329 Services on July 1, 2003:

2330 (a) to implement the federal health coverage tax credit program;

2331 (b) with federal funds; and

2332 (c) for qualified participants.

2333 (2) "Federal health coverage tax credit program" means the health care tax credit  
2334 program authorized by the Trade Reform Act.

2335 (3) "Qualified participant" means an individual:

2336 (a) eligible for coverage under the state program in accordance with Section  
2337 31A-38-103; and

2338 (b) qualified by the Internal Revenue Service and the Department of the United States  
2339 Treasury to participate in the federal health coverage tax credit program.

2340 (4) "State program" means the program established under this chapter:

2341 (a) to implement the federal health coverage tax credit program; and

2342 (b) for qualified participants.

2343 (5) "Trade Reform Act" means the Trade Adjustment Assistance Reform Act of 2002,  
2344 107 P.L. 210.

2345 Section 22. Section **31A-38-103** is enacted to read:

2346 **31A-38-103. Implementation of the federal health coverage tax credit program.**

2347 (1) An employee is considered to be an employee of the employee's last employer for  
2348 purposes of participating in the federal health coverage tax credit program if:

2349 (a) the employee is or was an employee of the employer;

2350 (b) the employer is or was doing business in this state;

- 2351 (c) the employee requires health care services from a licensed health care provider  
2352 doing business in this state;
- 2353 (d) the health insurance benefit plan covering the employee is terminated by the  
2354 employer or former employer; and
- 2355 (e) the employee is a qualified participant.
- 2356 (2) (a) Qualified participants eligible for the federal health coverage tax credit program  
2357 and qualifying family members of qualified participants shall be:
- 2358 (i) grouped together under the state program;  
2359 (ii) considered a single group risk pool; and  
2360 (iii) considered to be a group for purposes of:
- 2361 (A) implementing the federal health coverage tax credit program; and  
2362 (B) providing health insurance coverage.
- 2363 (b) The coverage provided to the group formed under this Subsection (2) shall be  
2364 considered to be group coverage.
- 2365 (c) Notwithstanding that the coverage is considered group coverage, a member of the  
2366 group may be individually underwritten and rated at the time of enrollment in the group.
- 2367 (3) (a) Except as expressly provided in this chapter, the state program is excluded from  
2368 regulation under this title if the state program:
- 2369 (i) meets the requirements of this Subsection (3) upon implementation of the state  
2370 program; and
- 2371 (ii) continuously complies with the requirements listed in this Subsection (3).
- 2372 (b) The Department of Workforce Services shall contract, in compliance with state  
2373 purchasing rules:
- 2374 (i) with an insurance company licensed to provide accident and health insurance:
- 2375 (A) to provide insurance for the state program;  
2376 (B) to assume the risk of the health insurance coverage of the qualified participants in  
2377 the state program; and
- 2378 (C) to take an action described in this Subsection (3)(b)(i) in consideration of receipt  
2379 of:
- 2380 (I) a reasonable premium from qualified participants; and  
2381 (II) the advance health coverage tax credits from the United States Treasury; or

2382 (ii) with a licensed third party administrator to administer the state program as a  
2383 self-insurance program that provides accident and health insurance coverage of the qualified  
2384 participants in the state program in consideration of receipt of:  
2385 (A) a reasonable premium from qualified participants; and  
2386 (B) the advance health coverage tax credit from the United States Treasury.  
2387 (c) (i) If the Department of Workforce Services contracts with a third party  
2388 administrator under Subsection (3)(b)(ii), the Department of Workforce Services shall create  
2389 and maintain a fund authorized under Subsection 31A-38-104(1)(b) to:  
2390 (A) pay claims covered by the state program; and  
2391 (B) receive the:  
2392 (I) reasonable premium from qualified participants; and  
2393 (II) advance health coverage tax credits from the United States Treasury.  
2394 (ii) The Department of Workforce Services shall ensure that the fund described in this  
2395 Subsection (3)(c):  
2396 (A) is actuarially sound upon implementation of the state program; and  
2397 (B) is continuously maintained and managed on an actuarially sound basis.  
2398 (iii) The actuarial soundness of a fund created pursuant to this Subsection (3)(c) shall  
2399 be supported by an opinion of an actuary that is a fellow in a nationally recognized actuary  
2400 association designated by the Department of Workforce Services.  
2401 (d) (i) The insurance company or third party administrator under contract with the  
2402 Department of Workforce Services shall:  
2403 (A) establish premium rates for health insurance coverage provided under this chapter  
2404 that are reasonable and actuarially sound to:  
2405 (I) cover the payment of existing claims; and  
2406 (II) build reasonable and adequate reserves to pay future claims; and  
2407 (B) adjust its premium rates as needed to:  
2408 (I) reflect the claim experience of the group;  
2409 (II) cover administrative and reinsurance costs related solely to the group;  
2410 (III) provide for a reasonable margin of profit from the group's coverage, not to exceed  
2411 15% of its premiums; and  
2412 (IV) build actuarially reasonable reserves for the payment of future claims.

- 2413 (ii) If the Department of Workforce Services creates a fund pursuant to Subsection  
 2414 (3)(c), the premiums paid by participants in the state program shall be designed to:  
 2415 (A) cover claims paid from the fund; and  
 2416 (B) to build reasonable and appropriate reserves for the payment of future claims.  
 2417 (e) (i) The insurance coverage designed by the insurance company or the third party  
 2418 administrator:  
 2419 (A) shall reflect the characteristics of the group;  
 2420 (B) shall meet the group's needs; and  
 2421 (C) may offer coverage that includes or does not include variable benefits.  
 2422 (ii) In designing the group coverage, the insurance company or third party  
 2423 administrator shall ensure that the coverage and the premiums are not discriminatory.  
 2424 (f) The coverage under the state program shall comply with:  
 2425 (i) all requirements of federal law pertaining to the federal health coverage tax credit  
 2426 program; and  
 2427 (ii) any federal requirement applicable to the health insurance coverage provided under  
 2428 the state program.  
 2429 (g) The commissioner shall approve:  
 2430 (i) the coverage design;  
 2431 (ii) the policy or coverage form; and  
 2432 (iii) the premium rates that are used to provide coverage under this section.  
 2433 (h) (i) The commissioner shall certify that the state program complies with the  
 2434 requirements of this chapter:  
 2435 (A) upon the initial implementation of the state program; and  
 2436 (B) every third year after implementation of the state program.  
 2437 (ii) If the Department of Workforce Services elects to operate the state program  
 2438 through a **§ [self insurance] SELF-INSURANCE §** program, before issuance of certification by the  
 2438a commissioner, the  
 2439 executive director of **§ THE §** Department of Workforce Services shall certify to the commissioner  
 2439a that:  
 2440 (A) the following are in compliance with the requirements of this Subsection (3):  
 2441 (I) state program coverage;  
 2442 (II) premium rates;  
 2443 (III) fund balances; and

2444 (IV) reserves; and

2445 (B) the state program is in compliance and will continue to be in compliance with the  
2446 requirements of this chapter and the Trade Reform Act.

2447 (4) Qualified participants enrolled in the bridge program prior to and after the effective  
2448 date of this chapter shall be enrolled in the state program provided for in this chapter

2449 retroactive to § [~~which ever~~] WHICHEVER § of the following dates ensures the continuance of health  
2449a insurance  
2450 coverage:

2451 (a) the date of their enrollment in the bridge program; or

2452 (b) July 1, 2003.

2453 (5) (a) The state is not liable, obligated, or responsible to guarantee the payment of  
2454 claims of qualified participants enrolled in the state program created by this chapter.

2455 (b) Any guaranty association created under Chapter 28, Guaranty Associations, is not  
2456 liable, obligated, or responsible to guarantee the payment of the claims of:

2457 (i) any fund created by this chapter; or

2458 (ii) the insurance company that is under contract with the Department of Workforce  
2459 Services to provide the health insurance coverage intended by this chapter.

2460 Section 23. Section **31A-38-104** is enacted to read:

2461 **31A-38-104. Interim Authorization -- Monies transferred for reserves --**

2462 **Reporting.**

2463 (1) Until July 1, 2005, the Department of Workforce Services may:

2464 (a) convert the bridge program to the state program through any of the following, or  
2465 combination of the following, that the Department of Workforce Services considers best serves  
2466 the needs of qualified participants:

2467 (i) a contract with a licensed insurance company authorized to do business in the state;

2468 (ii) through any other arrangement acceptable under the Trade Reform Act; or

2469 (iii) a § [~~self insurance~~] SELF-INSURANCE § program through a third party administrator as  
2469a provided in

2470 Subsection 31A-38-103(3)(b)(ii);

2471 (b) (i) in cooperation with the Division of Finance, establish an appropriate state fund  
2472 for the purpose of operation of the state program; and

2473 (ii) transfer the balance of any monies received under the bridge program into this  
2474 fund; and

2475 (c) obligate up to \$2,000,000 of the Workforce Services Special Administrative  
 2476 Expense Fund as reserves for the state program.

2477 (2) The monies in the fund created under Subsection (1)(b): **§ ARE §**

2478 (a) **§ [are] § nonlapsing; and**

2479 (b) restricted to the purposes of the state program established under this chapter.

2480 (3) The monies in Subsection (1)(c) may be:

2481 (a) used until the reserves in the state program become adequate; and

2482 (b) transferred into or out of any fund created under Subsection (1)(b).

2483 (4) If legislation is needed to continue the state program beyond July 1, 2005, the

2484 Department of Workforce Services shall prepare draft legislation to be presented to the

2485 Workforce Services and Community and Economic Development Interim Committee by

2486 November 30, 2004.

2487 Section 24. Section **63-55b-131** is amended to read:

2488 **63-55b-131. Repeal dates, Title 31A.**

2489 (1) Section 31A-22-626 is repealed July 1, 2004.

2490 (2) Section 31A-23a-415 is repealed July 1, 2006.

2491 (3) Title 31A, Chapter 38, Federal Health Care Tax Credit Program is repealed July 1,  
 2492 2005.

2493 Section 25. **Repealer.**

2494 This bill repeals:

2495 Section **31A-29-118, Employer contributions.**

2496 Section 26. **Effective date.**

2497 If approved by two-thirds of all the members elected to each house, Title 31, **§ A §** Chapter  
 2498 38, Federal Health Care Tax Credit Program Act, and the amendments in this bill to Section  
 2499 63-55b-131 take effect upon approval by the governor, or the day following the constitutional  
 2500 time limit of Utah Constitution Article VII, Section 8, without the governor's signature, or in  
 2501 the case of veto, the date of veto override.

2502 Section 27. **Revisor instructions.**

2503 It is the intent of the Legislature that in preparing the Utah Code database for  
 2504 publication the Office of Legislative Research and General Counsel shall change the reference  
 2505 in Subsection 31A-38-103(4) to "the effective date of this chapter" with the date that is the

2506 effective date of the chapter.