Summary of HB 39, Department of Insurance Amendments
1st Substitute (1-18-18)
Chief Sponsor: Representative James A. Dunnigan
Senate Sponsor: Senator Curtis S. Bramble

	Technical change: Formatting, numbering, word order, or language changes; no change in intent or practice; **Codifying existing practice:** New or changed language, no change in practice; **Policy Change:** New language, new practice.	
Lines	**Cite Change**	**Effect / Benefits**
	Note: The bill contains a number of non-substantive changes, primarily numbering, in various sections that are not highlighted below.	
	31A-1-301. Definitions.	
116-117	(1) (a) "Accident and health insurance" means insurance to provide protection against economic losses resulting from: . . . (d) For purposes of a national licensing registry, "accident and health insurance" is the same as "accident and health or sickness insurance."	**Codifying existing practice:** Updates terms consistent with those used in the licensing software from the National Insurance Producer Registry (NIPR).
609-610	(81) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec.155.20.	**Codifying existing practice:** moves definition from 31A-23b-102 to general definitions in 31A 1-301 and removes reference to a state-based small employer exchange by reference to 45 CFR 155.20. The change is needed due to the wind-down of Avenue H effective July 1, 2018.
630-636	[~~(88)~~] (89) "Insolvency" or "insolvent" means that: (a) an insurer is unable to pay [~~its debts or meet its obligations as the debts and obligations mature~~] the insurer's obligations as the obligations are due; (b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC under Subsection 31A-17-601(8)(c); or (c) an [~~insurer is determined to be hazardous under this title~~] insurer's admitted assets are less than the insurer's liabilities.	**Technical change:** changes definition to mirror definition in Chapter 27a (receivership) for consistency.
1011-1012	(140) "Preexisting condition," with respect to [~~a health benefit plan~~] health care insurance:	**Codifying existing practice:** clarifies the definition applies to health care insurance generally.

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	31A-2-201.1. General filing requirements.	
1332	Except as otherwise provided in this title, the commissioner may set by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specific requirements for filing any of the following required by this title: (1) a form; (2) a rate; [~~or~~] (3) a report[~~.~~]; or (4) a binder for a health benefit plan or dental policy.	**Codifying existing practice:** Since 2013 binders are required to be filed for plans offered under the ACA. This change codifies existing practice so the Department can enact regs to support binder filings for health benefit plans or dental contracts in compliance with the ACA.
	31A-2-201.2. Evaluation of health insurance market.	
1338	(1) Each year the commissioner shall: (a) conduct an evaluation of the state's health insurance market; (b) report the findings of the evaluation to the Health and Human Services Interim Committee before ~~October~~ December 1 of each year; and (c) publish the findings of the evaluation on the department website. . . .	**Codifiying existing practice:** Due to data availability utilized to generate the Health Insurance Market Report, the Department cannot produce the report by October 1. This change moves the report date to December 1, a more realistic target.
	31A-2-204. Conducting examinations.	
1367-1369 and 1458-1459	(1) As used in this section, "work papers" means a record that is created or relied upon: (a) during the course of an examination conducted under Section 31A-2-203; or (b) in drafting an examination report. . . . (12) Work papers are protected records under Title 63G, Chapter 2, Government Records Access and Management Act.	**Codifying existing practice:** Clarifies insurers' financial records utilized in the course of a statutory financial examination are protected records. Clarification also assures other state insurance departments we participate with in coordinated multi-state exams we can protect their records.
	31A-3-303. Payment of tax.	
1482-1490	[~~(4) Subject to Section 31A-3-305, if a policy covers risks that are only partially located in this state, for computation of tax under this part the premium shall be reasonably allocated among the states on the basis of risk locations. However, the premiums with respect to surplus lines insurance received in this state by a surplus lines producer or charged on policies written or negotiated in or from this state are taxable in full under this part, subject to a credit for any tax actually paid in another state to the extent of a reasonable allocation on the basis of risk locations.~~] (4) When Utah is the home state, premiums for surplus lines insurance are taxable in full.	**Codifying existing practice:** Clarifies Utah will collect 100% of surplus lines premium tax for Utah "home state" insureds as contemplated by the Dodd Frank Act and consistent will ALL other states. The Nonadmitted

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		Insurance Multi-State Agreement (NIMA) dissolved in 2017 and Utah no longer collects and shares multi-state surplus lines premium tax with other states.
	31A-8-104. Determination of ability to provide services. (HMOs)	
1499-1534	(1) The commissioner may not issue a certificate of authority to an applicant for certificate of authority under this chapter unless the applicant demonstrates to the commissioner [~~has determined~~] that the applicant has: (a) [~~demonstrated~~] the willingness and potential ability to furnish the proposed health care services in a manner to assure both availability and accessibility of adequate personnel and facilities and continuity of service; and (b) arrangements for an ongoing quality of health care assurance program concerning health care processes and outcomes[~~, established in accordance with rules adopted by the director of the Department of Health based upon prevailing standards for quality assurance for other forms of health care delivery in this state; and~~]. [~~(c) a procedure, established in accordance with rules of the director of the Department of Health, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required by the director of the Department of Health.~~] [~~(2) Upon receipt of an application for a certificate of authority under this chapter, the commissioner shall transmit a copy of the application and accompanying documents to the director of the Department of Health. Upon receipt of the application, the director of the Department of Health shall review the application, investigate the surrounding facts and circumstances, and make a finding concerning whether the applicant satisfies the requirements of Subsection (1). The director of the Department of Health is considered to have found the applicant to comply with Subsection (1) unless he delivers to the commissioner a finding of noncompliance within 90 days after receiving the application from the commissioner.~~] [~~(3) In determining whether the requirements of Subsection (1) are satisfied, the commissioner shall rely on the findings of the director of the Department of Health delivered to the commissioner in accordance with Subsection (2).~~] [~~(4) A finding of noncompliance with Subsection (1) shall specify in what respects the applicant is deficient in meeting the requirements of Subsection (1).~~] (2) (a) In accordance with Sections 31A-2-203 and 31A-2-204, the commissioner may order an independent audit or examination by one or more technical experts to determine an applicant's ability to provide the proposed health care services as described in Subsection (1). (b) In accordance with Section 31A-2-205, an applicant shall reimburse the commissioner for the reasonable cost of an independent audit or examination. [~~(5) An organization's certificate of authority issued under this chapter is conclusive evidence of compliance with Subsection (1), as to the services authorized to be performed under the certificate of authority, except in a proceeding by the state against the organization.~~]	**Policy change:** Removes requirement that an application for a new HMO be submitted to the Utah Department of Health for its compliance determination. Grants permissive authority for the commissioner to order an audit of an HMO applicant's provider network to ensure adequacy. Also requires the applicant to reimburse the commissioner for the cost of said audit.

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	31A-8a-102. Definitions. (health discount programs)	
1561-1562	As used in this chapter: . . . (6) "Marketing" means making or causing to be made any communication that contains information that relates to a product or contract regulated under this chapter.	**Codifying existing practice:** Clarifies what is considered "marketing" in the Health Discount Program Chapter.
	31A-15-103. Surplus lines insurance -- Unauthorized insurers.	
1627-1653	(6)(e) [~~A foreign~~] An unauthorized insurer shall be listed on the commissioner's "reliable" list only if the unauthorized insurer: (i) delivers a request to the commissioner to be on the list; (ii) establishes satisfactory evidence of good reputation and financial integrity; (iii) (A) delivers to the commissioner a copy of the unauthorized insurer's current annual statement certified by the insurer[~~; and~~] and, each subsequent year, delivers to the commissioner a copy of the unauthorized insurer's annual statement within 60 days after the day on which the unauthorized insurer files the annual statement with the insurance regulatory authority where the insurer is domiciled; or [~~(B) continues each subsequent year to file its annual statements with the commissioner within 60 days of the day on which it is filed with the insurance regulatory authority where the insurer is domiciled;~~] (B) files the unauthorized insurer's annual statements with the National Association of Insurance Commissioners and the unauthorized insurer's annual statements are available electronically from the National Association of Insurance Commissioners; (iv) (A) [~~(I)~~] is in substantial compliance with the solvency standards in Chapter 17, Part 6, Risk-Based Capital, or maintains capital and surplus of at least $15,000,000, whichever is greater; [~~and~~] or [~~(II) maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, or maintains a deposit meeting the statutory deposit requirements for insurers in the state where it is made, which trust fund or deposit:~~] [~~(Aa) shall be in an amount not less than $2,500,000 for the protection of all of the insurer's policyholders in the United States;~~] [~~(Bb) may consist of cash, securities, or investments of substantially the same character and quality as those which are "qualified assets" under Section 31A-17-201; and~~] [~~(Cc) may include as part of the trust arrangement a letter of credit that qualifies as acceptable security under Section 31A-17-404.1; or~~] (B) in the case of any "Lloyd's" or other similar incorporated or unincorporated group of alien individual insurers, maintains a trust fund that: (I) shall be in an amount not less than $50,000,000 as security to its full amount for all policyholders and creditors in the United States of each member of the group; (II) may consist of cash, securities, or investments of substantially the same character and quality as those which are "qualified assets" under Section 31A-17-201; and (III) may include as part of this trust arrangement a letter of credit that qualifies as acceptable security under Section	**Codifying existing practice:** Updates requirements for surplus lines insurers to be on the "reliable" list by allowing filing of required annual statements with the NAIC in lieu of filing with State to ease surplus lines insurers' regulatory burden. Revises and removes language that is inconsistent and redundant due to reference to Chapter 17 solvency standards for foreign (within the U.S.) surplus lines insurers, consistent with national standards.

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1743-1744	31A-17-404.1; and (v) for an alien insurer not domiciled in the United States or a territory of the United States, is listed on the Quarterly Listing of Alien Insurers maintained by the National Association of Insurance Commissioners International Insurers Department. . . . (11)(d) [~~(v) A stamping fee relative to a policy covering a risk located partially in this state shall be allocated in the same manner as under Subsection 31A-3-303(4).~~]	**Codifying existing practice:** Consistent with the change in 31A-3-303 (Utah collects 100% of multi-state surplus lines premium tax), clarifies the surplus lines stamping fee (.18 of 1%) is collected 100% by the Surplus Lines Association of Utah and not subject to allocation.
	31A-16-103. Acquisition of control of, divestiture of control of, or merger with domestic insurer.	
1980 2007-2017	(8) (a) The commissioner shall approve any merger or other acquisition of control referred to in Subsection (1)~~,~~ unless[~~, after a public hearing on the merger or acquisition,~~] the commissioner finds that: . . . (9) For a merger or other acquisition of control described in Subsection (1), the commissioner: (a) may hold a public hearing on the merger or other acquisition at the commissioner's discretion; and (b) shall hold a public hearing on the merger or other acquisition upon request by the acquiring party, the insurer, or any other interested party. [~~(9)~~] (10) (a) The commissioner shall hold a public hearing [~~referred to in Subsection (8) shall be held within 30~~] under Subsection (9) no later than 45 days after the day on which the statement required by Subsection (1) is filed. (b) (i) [~~At~~] The commissioner shall give at least 20 days notice of the hearing [~~shall be given by the commissioner~~] to the person filing the statement.	**Policy change:** Removes hearing mandate when a domestic insurer is acquired or there is a change of control. Gives commissioner discretion to require a hearing and requires a hearing if requested by the acquirer, the insurer being required or any interested party. After thorough vetting and statutory financial requirements are met, the vast majority of acquisitions are not adversarial, which makes the hearing requirement inefficient and unnecessary to have company officials and attorneys fly here for what is often a 20 minute proceeding.

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	31A-22-612. Conversion privileges for insured former spouse.	
2126 and 2134	(1) An accident and health insurance policy, which in addition to covering the insured also provides coverage to the spouse of the insured, may not contain a provision for termination of coverage of a spouse covered under the policy, except by entry of a valid decree of divorce, legal separation, or annulment between the parties. . . . (3) When the insurer receives actual notice that the coverage of a spouse is to be terminated because of a divorce, legal separation, or annulment, the insurer shall promptly provide the spouse written notification of the right to obtain individual coverage as provided in Subsection (2), the premium amounts required, and the manner, place, and time in which premiums may be paid. The premium is determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of the persons to be covered and to the type and amount of coverage provided. If the spouse applies and tenders the first monthly premium to the insurer within 30 days after receiving the notice provided by this Subsection (3), the spouse shall receive individual coverage that commences immediately upon termination of coverage under the insured's policy.	**Codifying existing practice:** adds legal separation to exceptions for when an accident and health policy covering more than one person may be terminated for one of the persons.
	31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit plans.	
2165-2169	(3) If a small employer [~~employs fewer than two eligible employees~~] no longer employs at least one eligible employee, a carrier may not discontinue or not renew the health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows at the beginning of the plan year that the employer no longer has at least [~~two current employees~~] one eligible employee.	**Technical change:** Updates language for consistency with the definition of a small employer. The definition indicates a small employer that does not have any "eligible employees" is exempted from renewing a group health benefit plan.
	31A-22-629. Adverse benefit determination review process.	
2265-2266	(1) As used in this section: . . . (b) "Independent review" means a process that: (i) is a voluntary option for the resolution of an adverse benefit determination; (ii) is conducted at the discretion of the claimant; (iii) is conducted by an independent review organization designated by the [~~insurer~~] commissioner; (iv) renders an independent and impartial decision on an adverse benefit determination submitted by an insured; and (v) may not require the insured to pay a fee for requesting the independent review.	**Codifying existing practice:** Clarifies the commissioner designates an independent review organization, not the insurer.
	31A-22-701. Groups eligible for group or blanket insurance.	
2333-2339	(2) A group accident and health insurance policy may be issued to: (a) a group: (i) to which a group life insurance policy may be issued under [~~Sections~~] Section 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-506, or 31A-22-507[~~, and 31A-22-509~~]; and (ii) that is formed and maintained in good faith for a purpose other than obtaining insurance;	**Codifying existing practice:** Clarifies that to be eligible to provide group insurance through an association the association must be authorized by the

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	(b) an association group authorized by the commissioner that:	commissioner.
	31A-22-722. Utah mini-COBRA benefits for employer group coverage.	
2467-2471	(5) (a) A premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy. (b) An insurer may not charge an insured an additional fee, an additional premium, interest, or any similar charge for electing extended group coverage. . . .	**Policy change:** Prohibits insurers from charging an insured covered under a Utah mini-COBRA plan additional fees or charges above the allowed 2% administrative fee.
2496-2500	(9) An insurer shall require an insured employer to offer to the following individuals an open enrollment period at the same time as other regular employees: (a) an individual who extends group coverage and is current on payment; and (b) during the applicable grace period described in Subsection (3) or (4), an individual who is eligible to elect to extend group coverage.	Mandates insurers require that their insured employers offer individual employees the same open enrollment periods offered regular employees.
	31A-23a-107. Character requirements. (producers)	
2506-2510	An applicant for a license under this chapter shall show to the commissioner that: (1) the applicant has the intent in good faith, to engage in the type of business that the license applied for would permit; (2) (a) if a natural person, the applicant is: (i) competent; and (ii) trustworthy; or (b) if the applicant is an agency:	**Codifying existing practice:** Clarifies that the 'competency' and 'trustworthy' requirements are separate and distinct requirements for obtaining a license.
	31A-23a-109. Nonresident jurisdictional agreement.	
2521-2540	(1) (a) If a nonresident license applicant has a valid producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary license from the nonresident license applicant's home state or designated home state and the conditions of Subsection (1)(b) are met, the commissioner shall: (i) waive the license requirements for a license under this chapter; and (ii) issue the nonresident license applicant a nonresident license. (b) Subsection (1)(a) applies if: (i) the nonresident license applicant: (A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or designated home state at the time the nonresident license applicant applies for a nonresident producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary license; (B) has submitted the proper request for licensure; (C) has submitted to the commissioner: (I) the application for licensure that the nonresident license applicant submitted to the applicant's home state or	**Codifying existing practice:** Codifies the applicability of the nonresident jurisdictional agreement statute where a "designated home state" is used when the resident state or territory does not offer a license for the line of authority sought (such as a title producer or a life consultant). The change is consistent with existing practice in keeping with the "designated home state" definition under Section 31A-23a-102.

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	designated home state; or (II) a completed uniform application; and (D) has paid the applicable fees under Section 31A-3-103; and (ii) the nonresident license applicant's license in the applicant's home state or designated home state is in good standing.	
	31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement. (producers)	
2648-2649	(5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may: (i) revoke: (A) a license; or (B) a line of authority; (ii) suspend for a specified period of 12 months or less: (A) a license; or (B) a line of authority; (iii) limit in whole or in part: (A) a license; or (B) a line of authority; (iv) deny a license application; (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and Subsection (5)(a)(v). (b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee: . . . (xiv) is convicted of: (A) a felony; or (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;	**Codifying existing practice:** The Department generally denies a license application by an individual convicted of a misdemeanor involving fraud, misrepresentation, theft or dishonesty. Currently the Department ties such a denial to an applicant's character requirement Section 31A-23a-107. This clarification will allow the applicant to better understand the requirements of licensure and specific reasons for denial. The change is also consistent with licensure requirements of the Department of Commerce.
	31A-23a-208. Producer and agency authority in health insurance exchange.	
2720-2729	A producer or agency licensed under this chapter, with a line of authority that permits the producer or agency to sell, negotiate, or solicit accident and health insurance, is authorized to sell, negotiate, or solicit qualified health plans offered on [~~an~~]a health insurance exchange [~~that is:~~ ~~(1) operated in the state; or~~ ~~(2) operated in the state and certified by the United States Department of Health and Human Services as a:~~ ~~(a) state-based exchange under PPACA;~~ ~~(b) a federally facilitated exchange under PPACA; or~~ ~~(c) a partnership exchange under PPACA~~].	**Codifying existing practice:** Removes reference to a health insurance exchange operated in the State as a state based or partnership exchange. This is needed due to the wind-down of Avenue H, effective July 1, 2018 as passed in the 2017 Session.

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	31A-23b-102. Definitions. (navigators)	
2742-2746	As used in this chapter: [~~(2) (a) "Exchange" means an online marketplace that is certified by the United States Department of Health and Human Services as either a state-based small employer exchange or a federally facilitated individual exchange under PPACA.~~] [~~(b) "Exchange" does not include an online marketplace for the purchase of health insurance if the online marketplace is not a certified exchange in accordance with Subsection (2)(a).~~]	**Codifying existing practice:** Removes definition from Chapter 23a, and moves it to 31A-1-301 under the term "health insurance exchange" since it is also used elsewhere in the Insurance Code under that term. The definition is updated in 31A-1-301 to remove reference to a state based small employer exchange due to the wind-down of Avenue H.
	31A-23b-202.5. License types. (navigators)	
2772	(3) (a) A navigator line of authority includes the enrollment process as described in Subsection 31A-23b-102[~~(3)~~](2)(a).	**Technical change:** Revises numbering due to deletion of the definition of "exchange" in 31A-23b-102.
	31A-23b-204 Character requirements. (navigators)	
2785-2787	An applicant for a license under this chapter shall demonstrate to the commissioner that: (1) the applicant has the intent, in good faith, to engage in the practice of a navigator as the license would permit; (2) (a) if a natural person, the applicant is: (i) competent; and (ii) trustworthy; or (b) if the applicant is an agency:	**Codifying existing practice:** Clarifies existing practice of considering "competency" and "trustworthy" to be separate and distinct requirements for obtaining a license.
	31A-23b-205. Examination and training requirements. (navigators)	
2821-2829	(5) (a) For the navigator line of authority, the training required by Subsection (1) shall consist of at least 21 credit hours of training before obtaining the license, which shall include[~~:(i) at least two hours of training on defined contribution arrangements and the small employer health insurance exchange; and (ii)~~] the navigator training and certification program developed by the Centers for Medicare and Medicaid Services. (b) For the certified application counselor line of authority, the training required by Subsection (1) shall consist of at least six hours of training before obtaining a license, which shall include[~~:(i) at least one hour of training on defined contribution arrangements and the small employer health insurance exchange; and(ii)~~] the certified application counselor training and certification program developed by the Centers for Medicare and Medicaid Services.	**Codifying existing practice:** Removes reference to one and two hour training requirements on defined contribution arrangements and the small employer health insurance exchange. This is needed due to the wind down of the operations of Avenue H.

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	31A-23b-206. Continuing education requirements.	
2851-2865	(3) (a) For a navigator line of authority, continuing education requirements shall require: . . . [~~(iii) that at least one of the 12 credit hours described in Subsection (3)(a)(i) be training on defined contribution arrangements and the use of the small employer health insurance exchange; and~~] . . . (b) For a certified application counselor, the continuing education requirements shall require: . . . [~~(iii) that at least one of the six credit hours described in Subsection (3)(b)(i) be training on defined contribution arrangements and the use of the small employer health insurance exchange; and~~]	**Codifying existing practice:** Removes the reference to the hour training requirement on defined contribution arrangements and use of the small employer health insurance exchange. This is needed due to the wind-down of Avenue H.
	31A-25-204. Character requirements. (TPAs)	
2895-2902	Each applicant for a license under this chapter shall show to the commissioner all of the following: (1) [~~he or it~~] that the applicant has the good faith intent to engage in the type of business the license applied for would permit; (2) (a) if a natural person, [~~he is~~] that the applicant is: (i) competent; and (ii) trustworthy[~~,~~]; or[~~,~~] (b) if a partnership or corporation, that all the partners, directors, principal officers, or persons having comparable powers are trustworthy; and	**Codifying existing practice:** Clarifies existing practice of considering 'competency' and 'trustworthy' as separate and distinct requirements for obtaining a license.
	31A-25-206. Nonresident jurisdictional agreement. (TPAs)	
2905-2926	(1) (a) If a nonresident license applicant has a valid license from the nonresident license applicant's home state or designated home state and the conditions of Subsection (1)(b) are met, the commissioner shall: (i) waive any license requirement for a license under this chapter; and (ii) issue the nonresident license applicant a nonresident third party administrator license. (b) Subsection (1)(a) applies if: (i) the nonresident license applicant: (A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or designated home state at the time the nonresident license applicant applies for a nonresident third party administrator license; (B) has submitted the proper request for licensure; (C) has submitted to the commissioner: (I) the application for licensure that the nonresident license applicant submitted to the applicant's home state or designated home state; or (II) a completed uniform application; and (D) has paid the applicable fees under Section 31A-3-103; (ii) the nonresident license applicant's license in the applicant's home state or designated home state is in good standing; and	**Codifying existing practice:** Codifies applicability of the nonresident jurisdictional agreement statute where a "designated home state" is to be used when the resident state or territory does not offer a third party administrator license for a line of authority sought in that state (such as workers' compensation). The change is consistent with existing practice with the "designated home state" definition under Section 31A-23a-102.

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	(iii) the nonresident license applicant's home state or designated home state awards nonresident third party administrator licenses to residents of this state on the same basis as this state awards licenses to residents of that home state or designated home state.	
	31A-26-102. Definitions. (adjusters)	
2942-2944	As used in this chapter, unless expressly provided otherwise: (1) "Company adjuster" means a person employed by an insurer [~~whose regular duties include insurance adjusting~~], or an entity under common control or ownership with the insurer, who negotiates or settles claims on behalf of the employer.	**Policy change:** Expands definition of company adjuster to include an affiliate of an insurer or other companies under common control and ownership with the insurer. The change is needed for consistency with other states, recognizing Utah adjusters are often also licensed as adjusters in multiple states.
	31A-26-205. Character requirements. (adjusters)	
2986-2991	Each applicant for a license under this chapter shall show to the commissioner that: (1) [~~he~~] the applicant has the good faith intent to engage in the type of business the license or licenses applied for would permit; (2) (a) if a natural person, [~~he is~~] the applicant is: (i) competent; and (ii) trustworthy[~~,~~]; or[~~ that,~~]	**Codifying existing practice:** Clarifies the existing practice of considering 'competency' and 'trustworthy' to be separate and distinct requirements for obtaining a license.
	31A-26-208. Nonresident jurisdictional agreement.	
	(1) (a) If a nonresident license applicant has a valid license from the nonresident license applicant's home state or designated home state and the conditions of Subsection (1)(b) are met, the commissioner shall: (i) waive any license requirement for a license under this chapter; and (ii) issue the nonresident license applicant a nonresident adjuster's license. (b) Subsection (1)(a) applies if: (i) the nonresident license applicant: (A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or designated home state at the time the nonresident license applicant applies for a nonresident adjuster license; (B) has submitted the proper request for licensure; (C) has submitted to the commissioner: (I) the application for licensure that the nonresident license applicant submitted to the applicant's home state or designated home state; or (II) a completed uniform application; and (D) has paid the applicable fees under Section 31A-3-103;	**Codifying existing practice:** Codifies applicability of the nonresident jurisdictional agreement statute where a "designated home state" is to be used when the resident state or territory does not offer a license for the line of authority. The change is consistent with existing practice with the "designated home state" definition under Section 31A-26-102.

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	(ii) the nonresident license applicant's license in the applicant's home state or designated home state is in good standing; and (iii) the nonresident license applicant's home state or designated home state awards nonresident adjuster licenses to residents of this state on the same basis as this state awards licenses to residents of that home state or designated home state.	
	31A-27a-111. Actions by and against the receiver.	
3073-3088	(5) (a) Subject to Subsection (5)(b), the following do not affect the amount that a receiver may recover from a third party, regardless of any provision in an agreement to the contrary: (i) the insurer's insolvency; or (ii) the insurer's or receiver's failure to pay all or a portion of an amount or a claim to the third party. (b) If an agreement between the insurer and a third party requires a payment by the insurer before the insurer may recover from the third party, the amount the receiver may recover from the third party under Subsection (5)(a) is limited to an amount equal to the greater of: (i) the amount paid by the insurer or by another person on behalf of the insurer to the third party; or (ii) the amount allowed as a claim for payment under: (A) an approved report described in Section 31A-27a-608; (B) an order of the receivership court; or (C) a plan of rehabilitation.	**Codifying existing practice:** Clarifies that the liabilities of an insolvent insurer are fixed as of the liquidation date (31A-27a-401(2)) and indemnitors of debtors, who are often bankrupt, that owe money to the insolvent insurer estate cannot benefit from the insurer's insolvency. This issue arises when an Indemnitor of a claim against the insolvent estate refuses to pay the indemnity because the insolvent company is unable to pay part or all of the underlying claims. To allow the Indemnitor to avoid paying its contractual indemnity because of the insurer's insolvency would deprive the insolvent insurer of the ability to collect assets to pay legitimate claims. The changes will reduce litigation that sometimes accompanies claims against indemnitors who allege no liability if the underlying claims is not paid.
	31A-27a-608. Liquidator's recommendations to the receivership court.	
3100-3103	(3) (a) A claim included in a report described in this section and approved by the receivership court is a liability of the estate. (b) An insurer's insolvency does not affect the amount of a liability described in Subsection (3)(a), regardless of any	**Codifying existing practice:** same explanation as above for 31A-27a-111.

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	provision in an agreement to the contrary.	
	31A-43-303. Stop-loss insurance disclosure.	
3118-3119	A stop-loss insurance contract delivered, issued for delivery, or entered into shall include the disclosure exhibit required by the commissioner through administrative rule, which shall include at least the following information: . . . (7) maximum claims liability to the employer[~~.~~]; and (8) a summary of the policy.	**Policy change:** Adds additional requirement that stop-loss policies delivered in the State include a summary of the policy.
	31A-45-403. Essential health benefits.	
3122-3136	(1) The state designates the state's own essential health benefits and does not accept a federal determination of the essential health benefits under the PPACA. (2) Subject to Subsections (3) and (4), the commissioner shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that designate the essential health benefits for the state. (3) Before the commissioner makes rules in accordance with Subsection (2): (a) the commissioner shall present a summary of the commissioner's planned rules to the Health Reform Task Force; and (b) the Health Reform Task Force shall recommend whether the commissioner makes rules in accordance with the presented summary. (4) The essential health benefits plan: (a) may not include a state mandate if the inclusion of the state mandate would require the state to contribute to premium subsidies under the PPACA; and (b) may add benefits in addition to the benefits included in a benchmark plan adopted in accordance with this section if the additional benefits are mandated under the PPACA.	**Codifies existing practice:** When managed care provisions were moved from Chapters 8, 22 and 30 to Chapter 45 during the 2017 General Legislative Session, 31A-30-116 was inadvertently repealed rather than moved. This section restores the previous language and updates it to reflect the Health System Reforms Task Force recommendation to declare the PEHP's Utah Basic Plus plan as the essential health benefit plan.
	63G-2-305. Protected records.	
	The following records are protected if properly classified by a governmental entity: . . . (68) work papers as defined in Section 31A-2-204.	**Codifying existing practice:** Clarifies insurers' financial records utilized in the course of a statutory financial examination are protected records. This clarification is also necessary to assure other state insurance departments we participate with in coordinated multi-state exams that we can protect their records.
	Repealer.	
	This bill repeals: Section **31A-22-722.5, Mini-COBRA election -- American Recovery and Reinvestment Act.**	Technical changes: both repealed statutes are antiquated

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	Section **31A-30-209, Insurance producers and the Health Insurance Exchange.**	laws no longer applicable. 31A-22-722.5 – appropriations have long since expired. 31A-30-209 - is no longer applicable due to the wind-down of Avenue H.