Utah Insurance Department
2020 Legislative Session
Summary of proposed policy changes in Title 31A as set forth in HB0037S01

Lines	Amendment text	Nature of change
127-283	**17B-2a-818.5. Contracting powers of public transit districts -- Health insurance coverage.** (1) As used in this section: (a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project. (b) "Change order" means the same as that term is defined in Section 63G-6a-103. (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who: (i) works at least 30 hours per calendar week; and (ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days after the day on which the individual is hired. (d) "Health benefit plan" means: (i) the same as that term is defined in Section 31A-1-301~~(.)~~[~~.~~] ; or (ii) an employee welfare benefit plan: (A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.; (B) for an employer with 100 or more employees; and (C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees. (e) "Qualified health [insurance] coverage" means the same as that term is defined in Section 26-40-115. (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208. (g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301. (2) Except as provided in Subsection (3), the requirements of this section apply to: (a) a contractor of a design or construction contract entered into by the public transit district on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and (b) a subcontractor of a contractor of a design or construction contract entered into by the public transit district on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.	***Policy Change:*** Expands an allowable health plan to include a self-funded employer with 100 or more employees.

	(3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if: (a) the application of this section jeopardizes the receipt of federal funds; (b) the contract is a sole source contract; or (c) the contract is an emergency procurement. (4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction. (5) (a) A contractor subject to the requirements of this section shall demonstrate to the public transit district that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employee's dependents during the duration of the contract by submitting to the public transit district a written statement that: (i) the contractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115; (ii) is from: (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~] (B) an underwriter who is responsible for developing the employer group's premium rates; [~~and{ }~~] or (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by a third party administrator; and (iii) was created within one year before the day on which the statement is submitted. (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the actuarial value of the health benefit plan meet the requirements of qualified health coverage. (ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to: (A) the actuary or underwriter selected by an administrator as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and (B) the public transit district. ~~[(b)]~~ (c) A contractor that is subject to the requirements of this section shall: (i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [~~insurance~~]	***Policy Change:*** Allows a contractor to use a third-party administrator's actuary or underwriter to demonstrate compliance with offering and maintaining a qualified health plan.

	coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and (ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that: (A) the subcontractor offers qualified health [insurance] coverage that complies with Section 26-40-115; (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and (C) was created within one year before the day on which the contractor obtains the statement. [~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [i~~nsurance~~] coverage as described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with an ordinance adopted by the public transit district under Subsection (6). (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[(~~b~~)] (c)(i). (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[(~~b~~)] (c)(i) during the duration of the subcontract is subject to penalties in accordance with an ordinance adopted by the public transit district under Subsection (6). (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a). (6) The public transit district shall adopt ordinances: (a) in coordination with: (i) the Department of Environmental Quality in accordance with Section 19-1-206; (ii) the Department of Natural Resources in accordance with Section 79-2-404; (iii) the State Building Board in accordance with Section 63A-5-205.5; (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and (v) the Department of Transportation in accordance with Section 72-6-107.5; and (b) that establish: (i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including: (A) that a contractor or subcontractor's compliance with this section is subject to an audit by the public transit district or the Office of the Legislative Auditor General;	

	(B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and (C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[(~~b~~)] ~~(c)~~(ii); (ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include: (A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the public transit district upon the first violation; (B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the public transit district upon the second violation; (C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and (D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [~~insurance~~] coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health [insurance] coverage during the duration of the contract; and (iii) a website on which the district shall post the commercially equivalent benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is provided by the Department of Health, in accordance with Subsection 26-40-115(2). (7) (a) (i) In addition to the penalties imposed under Subsection (6)(b)(ii), a contractor or subcontractor who intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage. (ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if: (A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)[(~~b~~)] (c)(ii); or (B) a department or division determines that compliance with this section is not required under the provisions of Subsection (3). (b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7). (8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402. (9) The failure of a contractor or subcontractor to provide qualified health [insurance] coverage as required by this section:	

	(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under: (i) Section 63G-6a-1602; or (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and (b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction. (10) An administrator, including an administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in Subsection (1)(d)(ii): (a) subject to Subsection (10)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement; (b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and (c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.	***Policy Change:*** Provides that an administrator's actuary or underwriter is not liable for information provided in good faith regarding a contractor's qualified health plan.
Lines	**Amendment text**	**Nature of change**
284-452	**19-1-206. Contracting powers of department -- Health insurance coverage.** (1) As used in this section: (a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project. (b) "Change order" means the same as that term is defined in Section 63G-6a-103. (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who: (i) works at least 30 hours per calendar week; and (ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days after the day on which the individual is hired. (d) "Health benefit plan" means: (i) the same as that term is defined in Section 31A-1-301~~(.)~~[.] ; or (ii) an employee welfare benefit plan: (A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.; (B) for an employer with 100 or more employees; and	***Policy Change:*** Expands an allowable health plan to include a self-funded employer with 100 or more employees.

	(C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees. (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in Section 26-40-115. (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208. (g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301. (2) Except as provided in Subsection (3), the requirements of this section apply to: (a) a contractor of a design or construction contract entered into by, or delegated to, the department, or a division or board of the department, on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and (b) a subcontractor of a contractor of a design or construction contract entered into by, or delegated to, the department, or a division or board of the department, on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000. (3) This section does not apply to contracts entered into by the department or a division or board of the department if: (a) the application of this section jeopardizes the receipt of federal funds; (b) the contract or agreement is between: (i) the department or a division or board of the department; and (ii) (A) another agency of the state; (B) the federal government; (C) another state; (D) an interstate agency; (E) a political subdivision of this state; or (F) a political subdivision of another state; (c) the executive director determines that applying the requirements of this section to a particular contract interferes with the effective response to an immediate health and safety threat from the environment; or (d) the contract is: (i) a sole source contract; or (ii) an emergency procurement. (4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction.	

	(5) (a) A contractor subject to the requirements of this section shall demonstrate to the executive director that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the duration of the contract by submitting to the executive director a written statement that: (i) the contractor offers qualified health [insurance] coverage that complies with Section 26-40-115; (ii) is from: (A) an actuary selected by the contractor or the contractor's insurer; [or] (B) an underwriter who is responsible for developing the employer group's premium rates; [~~and~~{ }] or (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by a third party administrator; and (iii) was created within one year before the day on which the statement is submitted. (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the actuarial value of the health benefit plan meet the requirements of qualified health coverage. (ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to: (A) the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and (B) the department. [(~~b~~)] (c) A contractor that is subject to the requirements of this section shall: (i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [insurance] coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and (ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that: (A) the subcontractor offers qualified health [insurance] coverage that complies with Section 26-40-115;	***Policy Change:*** Allows a contractor to use a third-party administrator's actuary or underwriter to demonstrate compliance with offering and maintaining a qualified health plan.

	(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and (C) was created within one year before the day on which the contractor obtains the statement. [(~~c~~)] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6). (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[(~~b~~)] (c)(i). (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[(b)](c) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6). (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [insurance] coverage described in Subsection (5)(a). (6) The department shall adopt administrative rules: (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; (b) in coordination with: (i) a public transit district in accordance with Section 17B-2a-818.5; (ii) the Department of Natural Resources in accordance with Section 79-2-404; (iii) the State Building Board in accordance with Section 63A-5-205.5; (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; (v) the Department of Transportation in accordance with Section 72-6-107.5; and (vi) the Legislature's Administrative Rules Review Committee; and (c) that establish: (i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including: (A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General; (B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and (C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[(~~b~~)] (c)(ii);	

	(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include: (A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation; (B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation; (C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and (D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [insurance] coverage for an employee and the dependents of an employee of the contractor or subcontractor who was not offered qualified health [~~insurance~~] coverage during the duration of the contract; and (iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is provided by the Department of Health, in accordance with Subsection 26-40-115(2). (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage. (ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if: (A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)[(~~b~~)] (c)(ii); or (B) the department determines that compliance with this section is not required under the provisions of Subsection (3). (b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7). (8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402. (9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~] coverage as required by this section: (a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under: (i) Section 63G-6a-1602; or (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and	

	(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction. (10) An administrator, including an administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in Subsection (1)(d)(ii): (a) subject to Subsection (10)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement; (b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and (c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.	***Policy Change:*** Provides that an administrator's actuary or underwriter is not liable for information provided in good faith regarding a contractor's qualified health plan.
Lines	**Amendment text**	**Nature of change**
488-647	**31A-1-103. Scope and applicability of title.** *** (6)(c) This title does not apply to: (i) a manufacturer's or seller's warranty; (ii) a manufacturer's or seller's service contract paid for with consideration that is in addition to the consideration paid for the product itself; and (iii) a service contract that is not a manufacturer's or seller's warranty or manufacturer's or seller's service contract if: (A) the service contract is paid for with consideration that is in addition to the consideration paid for the product itself; (B) the service contract is for the repair or maintenance of goods; (C) the purchase price ~~cost~~ of the product is $3,700 or less ~~an amount determined in accordance with Subsection (6)(e)~~; ~~and~~ (D) the product is not a motor vehicle; and~~.~~ (E) the product is not the subject of a home warranty service contract. (d) This title does not apply to a manufacturer's or seller's warranty or service contract paid for with consideration that is in addition to the consideration paid for the product itself regardless of whether the manufacturer's or seller's warranty or service contract is sold: (i) at the time of the purchase of the product; or (ii) at a time other than the time of the purchase of the product.	***Policy change:*** Enacts a bright-line dollar amount for determining whether Chapter 6a applies to a service contract. ***Policy change:*** Excludes home warranty service contracts from the exclusion from Chapter 6a.

	~~(e)(i) For fiscal year 2001-02, the amount described in Subsection (6)(c)(iii)(C) shall be equal to $3,700 or less.~~ ~~(ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually determine whether the amount described in Subsection (6)(c)(iii)(C) should be adjusted in accordance with changes in the Consumer Price Index published by the United States Bureau of Labor Statistics selected by the commissioner by rule, between:~~ ~~(A) the Consumer Price Index for the February immediately preceding the adjustment; and~~ ~~(B) the Consumer Price Index for February 2001.~~ ~~(iii) If under Subsection (6)(e)(ii) the commissioner determines that an adjustment should be made, the commissioner shall make the adjustment by rule.~~	***Policy change:*** Eliminates the complicated method for determining the dollar amount of a purchase that is governed by Chapter 6a.
Lines	**Amendment text**	**Nature of change**
649- 1911 1303- 1309	**31A-1-301. Definitions.** As used in this title, unless otherwise specified: *** (104) ~~[(a)]~~ "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year: ~~[(i)]~~ (a) employed an average of at least 51 employees on business days during the preceding calendar year; and ~~[(ii)]~~ (b) employs at least one employee on the first day of the plan year. ~~[(b) The number of employees shall be determined using the method set forth in 26 U.S.C. Sec. 4980H(c)(2).~~]	***Policy Change:*** Changes the definition so it aligns with the definition of small employer. Current language creates conflicts on larger small employers and smaller large employers.
Lines	**Amendment text**	**Nature of change**
2060- 2140	**31A-2-403. Title and Escrow Commission created.** (1)(a) Subject to Subsection (1)(b), there is created within the department the Title and Escrow Commission that is comprised of five members appointed by the governor with the consent of the Senate as follows: (i) except as provided in Subsection [~~(1)(c)~~] (1)(d), two members shall be employees of a title insurer; (ii) two members shall: (A) be employees of a Utah agency title insurance producer; (B) be or have been licensed under the title insurance line of authority; (C) as of the day on which the member is appointed, be or have been licensed with the title examination or escrow subline of authority for at least five years; and	

	(D) as of the day on which the member is appointed, not be from the same county as another member appointed under this Subsection (1)(a)(ii); and (iii) one member shall be a member of the general public from any county in the state. (b) No more than one commission member may be appointed from a single company or an affiliate or subsidiary of the company. (c) No more than two commission members may be employees of an entity operating under an affiliated business arrangement as defined in Section 31A-23a-1001. (d[~~c~~]) If the governor is unable to identify more than one individual who is an employee of a title insurer and willing to serve as a member of the commission, the commission shall include the following members in lieu of the members described in Subsection (1)(a)(i): (i) one member who is an employee of a title insurer; and (ii) one member who is an employee of a Utah agency title insurance producer. (Subsections (2)-(7) omitted)	***Policy change:*** Title 31A, Chapter 23a Part 10 allows agency title insurance producers to operate under an "affiliated business arrangement" as defined in Section 31A-23a-1101(2). This amendment assures that both affiliated and nonaffiliated agency title insurance producers are represented on the commission.
Lines	**Amendment text**	**Nature of change**
2290-2386	**31A-6a-104. Required disclosures.** (1) A reimbursement insurance policy insuring a service contract or a vehicle protection product warranty that is issued, sold, or offered for sale in this state shall conspicuously state that, upon failure of the service contract provider or warrantor to perform under the contract, the issuer of the policy shall: (a) pay on behalf of the service contract provider or warrantor any sums the service contract provider or warrantor is legally obligated to pay according to the service contract provider's or warrantor's contractual obligations under the service contract or a vehicle protection product warranty issued or sold by the service contract provider or warrantor; or (b) provide the service which the service contract provider is legally obligated to perform, according to the service contract provider's contractual obligations under the service contract issued or sold by the service contract provider. (2)(a) A service contract may not be issued, sold, or offered for sale in this state unless the service contract contains the following statements in substantially the following form: (i) "Obligations of the provider under this service contract are guaranteed under a service contract reimbursement insurance policy. Should the provider fail to pay or provide service on any claim within 60 days after proof of loss has been filed, the contract holder is entitled to make a claim directly against the Insurance Company.";	

	(ii) "This service contract or warranty is subject to limited regulation by the Utah Insurance Department. To file a complaint, contact the Utah Insurance Department."; and (iii) A service contract or reimbursement insurance policy may not be issued, sold, or offered for sale in this state unless the contract contains a statement in substantially the following form, "Coverage afforded under this contract is not guaranteed by the Property and Casualty Guaranty Association." (b) A vehicle protection product warranty may not be issued, sold, or offered for sale in this state unless the vehicle protection product warranty contains the following statements in substantially the following form: (i) "Obligations of the warrantor under this vehicle protection product warranty are guaranteed under a reimbursement insurance policy. Should the warrantor fail to pay on any claim within 60 days after proof of loss has been filed, the warranty holder is entitled to make a claim directly against the Insurance Company."; (ii) "This vehicle protection product warranty is subject to limited regulation by the Utah Insurance Department. To file a complaint, contact the Utah Insurance Department."; and (iii) as applicable: (A) "The warrantor under this vehicle protection product warranty will reimburse the warranty holder as specified in the warranty upon the theft of the vehicle."; or (B) "The warrantor under this vehicle protection product warranty will reimburse the warranty holder as specified in the warranty and at the end of the time period specified in the warranty if, following the theft of the vehicle, the stolen vehicle is not recovered within a time period specified in the warranty, not to exceed 30 days after the day on which the vehicle is reported stolen." (c) A vehicle protection product warranty, or reimbursement insurance policy, may not be issued, sold, or offered for sale in this state unless the warranty contains a statement in substantially the following form, "Coverage afforded under this warranty is not guaranteed by the Property and Casualty Guaranty Association." (3) A service contract and a vehicle protection product warranty shall: (a) conspicuously state the name, address, and a toll free claims service telephone number of the reimbursement insurer; (b)(i) identify the service contract provider, the seller, and the service contract holder; or (ii) identify the warrantor, the seller, and the warranty holder; (c) conspicuously state the total purchase price and the terms under which the service contract or warranty is to be paid; (d) conspicuously state the existence of any deductible amount; (e) specify the merchandise, service to be provided, and any limitation, exception, or exclusion;	

	(f) state a term, restriction, or condition governing the transferability of the service contract or warranty; and (g) state a term, restriction, or condition that governs cancellation of the service contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder or service contract provider. (4) If prior approval of repair work is required [~~,a service~~] under a home protection service contract or a vehicle service contract, the contract shall conspicuously state the procedure for obtaining prior approval and for making a claim, including: (a) a toll free telephone number for claim service; and (b) a procedure for obtaining reimbursement for emergency repairs performed outside of normal business hours. *** (8) (a) As used in this Subsection (8), "conspicuous statement" means a disclosure that: (i) appears in all-caps, bold, and 14-point font; and (ii) provides a space to be initialed by the consumer: (A) immediately below the printed disclosure; and (B) at or before the time the consumer purchases the vehicle protection product. (b) (i) A vehicle protection product warranty shall contain a conspicuous statement in substantially the following form: "Purchase of this product is optional and is not required in order to finance, lease, or purchase a motor vehicle." (ii) Beginning January 1, 2021, a service contract shall contain a conspicuous statement in substantially the following form: "Purchase of this product is optional and is not required in order to finance, lease, or purchase a motor vehicle." Subsections (5) - (7) and (9) - (10) omitted.	***Policy change:*** Only home protection service contracts and vehicle service contracts, not all service contracts, must state a procedure for obtaining prior approval and for making a claim. ***Policy change:*** Requires a notice to consumers that purchase of a service contract is not required to purchase a product.
Lines	**Amendment text**	**Nature of change**
2388- 2425	**31A-8-211. Deposit.** (1) Except as provided in Subsection (2), each health maintenance organization authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the sum of: (a) $100,000; and (b) 50% of the greater of: (i) $900,000;	

	(ii) 2% of the annual premium revenues as reported on the most recent annual financial statement filed with the commissioner; or (iii) an amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner. (2)(a) [~~After a hearing~~] [~~t~~]The commissioner may exempt a health maintenance organization from the deposit requirement of Subsection (1) if: (i) the commissioner determines that the enrollees' interests are adequately protected; (ii) the health maintenance organization has been continuously authorized to do business in this state for at least five years; and (iii) the health maintenance organization has $5,000,000 surplus in excess of the health maintenance organization's company action level RBC as defined in Subsection 31A-17-601(8)(b). (b) The commissioner may rescind an exemption given under Subsection (2)(a). (3)(a) Each limited health plan authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the minimum capital or permanent surplus plus 50% of the greater of: (i) .5 times minimum required capital or minimum permanent surplus; or (ii)(A) during the first year of operation, 10% of the limited health plan's projected uncovered expenditures for the first year of operation; (B) during the second year of operation, 12% of the limited health plan's projected uncovered expenditures for the second year of operation; (C) during the third year of operation, 14% of the limited health plan's projected uncovered expenditures for the third year of operation; (D) during the fourth year of operation, 18% of the limited health plan's projected uncovered expenditures during the fourth year of operation; or (E) during the fifth year of operation, and during all subsequent years, 20% of the limited health plan's projected uncovered expenditures for the previous 12 months. (b) Projections of future uncovered expenditures shall be established in a manner that is approved by the commissioner. (4) A deposit required by this section may be counted toward the minimum capital or minimum permanent surplus required under Section 31A-8-209.	***Policy change:*** The Department has determined that an initial hearing is unnecessary. The law provides an opportunity for a hearing, if requested, after the commissioner's decision is issued.
Lines	**Amendment text**	
2427-2987	**31A-17-404. Credit allowed a domestic ceding insurer against reserves for reinsurance.**	***Policy change:*** The National Association of Insurance Commissioners ("NAIC"), the

	(1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of Subsection (3), (4), (5), (6), (7), [~~or~~] (8) or (9), subject to the following: (a) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a kind or class of business that the assuming insurer is licensed or otherwise permitted to write or assume: (i) in its state of domicile; or (ii) in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. (b) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of Subsection ([~~9~~]11) are met. (2) A domestic ceding insurer is allowed credit for reinsurance ceded: (a) only if the reinsurance is payable in a manner consistent with Section 31A-22-1201; (b) only to the extent that the accounting: (i) is consistent with the terms of the reinsurance contract; and (ii) clearly reflects: (A) the amount and nature of risk transferred; and (B) liability, including contingent liability, of the ceding insurer; (c) only to the extent the reinsurance contract shifts insurance policy risk from the ceding insurer to the assuming reinsurer in fact and not merely in form; and (d) only if the reinsurance contract contains a provision placing on the reinsurer the credit risk of all dealings with intermediaries regarding the reinsurance contract. (3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state. (4)(a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state. (b) An insurer is accredited as a reinsurer if the insurer: (i) files with the commissioner evidence of the insurer's submission to this state's jurisdiction; (ii) submits to the commissioner's authority to examine the insurer's books and records; (iii)(A) is licensed to transact insurance or reinsurance in at least one state; or (B) in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state; (iv) files annually with the commissioner a copy of the insurer's: (A) annual statement filed with the insurance department of its state of domicile; and (B) most recent audited financial statement; and	Federal Insurance Office ("FIO") and other agencies have negotiated with the U.K. and the European Union the terms of a law that allows insurance companies to receive credit for reinsurance ceded to international firms. The terms of the law are embodied in the amendments to Utah Code § 31A-17-404. Because of the difficulty of the negotiations, the NAIC and Federal Insurance Office recommend that the exact language of the law be adopted. They discourage changes that will suit the statutory drafting rules of individual states. States have until 10/1/22 to adopt the agreement in statute or face federal preemption. The Federal Insurance Office begins its preemption analysis on April 1, 2021. Accordingly, Utah should adopt the agreement during the 2020 legislative session. The amendment allows credit for reinsurance where the reinsurer is domiciled or licensed in a "Reciprocal Jurisdiction."

	(v)(A)(I) has not had its accreditation denied by the commissioner within 90 days of the day on which the insurer submits the information required by this Subsection (4); and (II) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; or (B)(I) has its accreditation approved by the commissioner; and (II) maintains a surplus with regard to policyholders in an amount less than $20,000,000. (c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation is revoked by the commissioner after a notice and hearing. (5)(a) A domestic ceding insurer is allowed a credit if: (i) the reinsurance is ceded to an assuming insurer that is: (A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or (B) in the case of a United States branch of an alien assuming insurer, is entered through a state meeting the requirements of Subsection (5)(a)(ii); (ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for reinsurance substantially similar to those applicable under this section; and (iii) the assuming insurer or United States branch of an alien assuming insurer: (A) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; and (B) submits to the authority of the commissioner to examine its books and records. (b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded and assumed pursuant to a pooling arrangement among insurers in the same holding company system. (6)(a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund: (i) created in accordance with rules made by the commissioner pursuant to Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and (ii) in a qualified United States financial institution for the payment of a valid claim of: (A) a United States ceding insurer of the assuming insurer; (B) an assign of the United States ceding insurer; and (C) a successor in interest to the United States ceding insurer. (b) To enable the commissioner to determine the sufficiency of the trust fund described in Subsection (6)(a), the assuming insurer shall: (i) report annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by a licensed insurer; and (ii)(A) submit to examination of its books and records by the commissioner; and (B) pay the cost of an examination.	• A Reciprocal Jurisdiction is a non-U.S. jurisdiction that has either: (a) entered into a reinsurance credit treaty with the U.S., or (b) has not entered into such a treaty but is qualified to be considered for certification. • A reinsurer from a Reciprocal Jurisdiction must meet minimum solvency and surplus requirements set by the commissioner, must give notice if it falls below solvency or surplus requirements or is subject to regulatory action, must comply with administrative requirements imposed by the commissioner and must provide security equal to 100% of its reinsurance liabilities. • The NAIC will publish a list of Reciprocal Jurisdictions to which the commissioner may defer. • The commissioner shall publish a list of Reciprocal Jurisdictions and may add to the list any jurisdiction that has been deemed a

	(c)(i) Credit for reinsurance may not be granted under this Subsection (6) unless the form of the trust and any amendment to the trust is approved by: (A) the commissioner of the state where the trust is domiciled; or (B) the commissioner of another state who, pursuant to the terms of the trust instrument, accepts principal regulatory oversight of the trust. (ii) The form of the trust and an amendment to the trust shall be filed with the commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled. (iii) The trust instrument shall provide that a contested claim is valid and enforceable upon the final order of a court of competent jurisdiction in the United States. (iv) The trust shall vest legal title to its assets in its one or more trustees for the benefit of: (A) a United States ceding insurer of the assuming insurer; (B) an assign of the United States ceding insurer; or (C) a successor in interest to the United States ceding insurer. (v) The trust and the assuming insurer are subject to examination as determined by the commissioner. (vi) The trust shall remain in effect for as long as the assuming insurer has an outstanding obligation due under a reinsurance agreement subject to the trust. (vii) No later than February 28 of each year, the trustee of the trust shall: (A) report to the commissioner in writing the balance of the trust; (B) list the trust's investments at the end of the preceding calendar year; and (C)(I) certify the date of termination of the trust, if so planned; or (II) certify that the trust will not expire prior to the following December 31. (d) The following requirements apply to the following categories of assuming insurer: (i) For a single assuming insurer: (A) the trust fund shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and (B) the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in Subsection (6)(d)(ii). (ii)(A) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development.	Reciprocal Jurisdiction by an NAIC-accredited state. The changes described above are at pp. 33-40 of this outline.

	(B) The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. (C) The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust. (iii) For a group acting as assuming insurer, including incorporated and individual unincorporated underwriters: (A) for reinsurance ceded under a reinsurance agreement with an inception, amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to an underwriter of the group; (B) for reinsurance ceded under a reinsurance agreement with an inception date on or before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the other provisions of this chapter, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; (C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall maintain in trust a trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group for all years of account; (D) the incorporated members of the group: (I) may not be engaged in a business other than underwriting as a member of the group; and (II) are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members; and (E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner: (I) an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or (II) if a certification is unavailable, a financial statement, prepared by an independent public accountant, of each underwriter member of the group. (iv) For a group of incorporated underwriters under common administration, the group shall: (A) have continuously transacted an insurance business outside the United States for at least three years immediately preceding the day on which the group makes application for accreditation;	

	(B) maintain aggregate policyholders' surplus of at least $10,000,000,000; (C) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to a member of the group pursuant to a reinsurance contract issued in the name of the group; (D) in addition to complying with the other provisions of this Subsection (6)(d)(iv), maintain a joint trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group as additional security for these liabilities; and (E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner: (I) an annual certification of each underwriter member's solvency by the member's domiciliary regulator; and (II) a financial statement of each underwriter member of the group prepared by an independent public accountant. [~~(7) If reinsurance is ceded to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law or regulation of that jurisdiction.~~] (7[~~8~~]) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that secures its obligations in accordance with this Subsection ([~~8~~]7): (a) The insurer shall be certified by the commissioner as a reinsurer in this state. (b) To be eligible for certification, the assuming insurer shall: (i) be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to Subsection ([~~8~~]7)(d); (ii) maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; (iii) maintain financial strength ratings from two or more rating agencies considered acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and (iv) agree to: (A) submit to the jurisdiction of this state; (B) appoint the commissioner as its agent for service of process in this state; (C) provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;	

	(D) agree to meet applicable information filing requirements as determined by the commissioner including an application for certification, a renewal and on an ongoing basis; and (E) any other requirements for certification considered relevant by the commissioner. (c) An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer. To be eligible for certification, in addition to satisfying requirements of Subsections ([~~8~~]7)(a) and (b), the association: (i) shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members in an amount determined by the commissioner to provide adequate protection; (ii) may not have incorporated members of the association engaged in any business other than underwriting as a member of the association; (iii) shall be subject to the same level of regulation and solvency control of the incorporated members of the association by the association's domiciliary regulator as are the unincorporated members; and (iv) within 90 days after its financial statements are due to be filed with the association's domiciliary regulator provide: (A) to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or (B) if a certification is unavailable, financial statements prepared by independent public accountants, of each underwriter member of the association. (d) The commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer. (i) To determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner: (A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis; (B) shall consider the rights, the benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States; (C) shall require the qualified jurisdiction to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and	

	(D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. (ii) The commissioner may consider additional factors in determining a qualified jurisdiction. (iii) A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners' Committee Process and the commissioner shall: (A) consider this list in determining qualified jurisdictions; and (B) if the commissioner approves a jurisdiction as qualified that does not appear on the National Association of Insurance Commissioner's list of qualified jurisdictions, provide thoroughly documented justification in accordance with criteria to be developed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. (iv) United States jurisdictions that meet the requirement for accreditation under the National Association of Insurance Commissioners' financial standards and accreditation program shall be recognized as qualified jurisdictions. (v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation. (e) The commissioner shall: (i) assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies considered acceptable to the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and (ii) publish a list of all certified reinsurers and their ratings. (f) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this Subsection ([~~8~~]7) at a level consistent with its rating, as specified in rules made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. (i) For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a multibeneficiary trust in accordance with Subsections (5), (6), and ([~~7~~]9), except as otherwise provided in this Subsection ([~~8~~]7). (ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to Subsections (5), (6), and ([~~7~~]9), and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with	

	reduced security as permitted by this Subsection ([~~8~~]7) or comparable laws of other United States jurisdictions and for its obligations subject to Subsections (5), (6), and ([~~7~~]9). (iii) It shall be a condition to the grant of certification under this Subsection ([~~8~~]7) that the certified reinsurer shall have bound itself: (A) by the language of the trust and agreement with the commissioner with principal regulatory oversight of the trust account; and (B) upon termination of the trust account, to fund, out of the remaining surplus of the trust, any deficiency of any other trust account. (iv) The minimum trusteed surplus requirements provided in Subsections (5), (6), and ([~~7~~]9) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this Subsection ([~~8~~]7), except that the trust shall maintain a minimum trusteed surplus of $10,000,000. (v) With respect to obligations incurred by a certified reinsurer under this Subsection ([~~8~~]7), if the security is insufficient, the commissioner: (A) shall reduce the allowable credit by an amount proportionate to the deficiency; and (B) may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due. (vi) For purposes of this Subsection ([~~8~~]7), a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100% of its obligations. (A) As used in this Subsection ([~~8~~]7), the term "terminated" refers to revocation, suspension, voluntary surrender, and inactive status. (B) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, the requirement under this Subsection ([~~8~~]7)(f)(vi) does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended. (g) If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners' accredited jurisdiction, the commissioner may: (i) defer to that jurisdiction's certification; (ii) defer to the rating assigned by that jurisdiction; and (iii) consider such reinsurer to be a certified reinsurer in this state. (h)(i) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business.	

	(ii) An inactive certified reinsurer shall continue to comply with all applicable requirements of this Subsection ([~~8~~]7). (iii) The commissioner shall assign a rating to a reinsurer that qualifies under this Subsection ([~~8~~]7)(h), that takes into account, if relevant, the reasons why the reinsurer is not assuming new business. (8) (a) As used in this Subsection (8): (i) "Covered agreement" means an agreement entered into pursuant to Dodd-Frank 2345 Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance. (ii) "Reciprocal jurisdiction" means a jurisdiction that is: (A) a non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union; (B) a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners' financial standards and accreditation program; or (C) a qualified jurisdiction, as determined by the commissioner in accordance with Subsection (7)(d), that is not otherwise described in this Subsection (8)(a)(ii) and meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in rule made in accordance with Title 63G, 2361 Chapter 3, Utah Administrative Rulemaking Act. (b) (i) Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth in this Subsection (8)(b). (ii) The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction. (iii) (A) The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in regulation. (B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in regulation.	

	(iv) (A) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ration, as applicable, which will be set forth in regulation. (B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed. (v) The assuming insurer must agree and provide adequate assurance to the commissioner, in a form specified by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as follows: (A) the assuming insurer must provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in Subsections (8)(c) or (d), or if any regulatory action is taken against it for serious noncompliance with applicable law; (B) the assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process, however the commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement and nothing in this provision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws; (C) the assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained; (D) each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and (E) the assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involved this state's ceding insurers, and agree to notify the ceding insurer and the commissioner and to provide security: (I) in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement; and (II) in a form consistent with the provisions of Subsections (7) and (10) and as specified by the commissioner in regulation.	

	(vi) The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, certain documentation to the commissioner, as specified by the commissioner by rule made in accordance with Title 63G, 2412 Chapter 3, Utah Administrative Rulemaking Act. (vii) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. (viii) The assuming insurer's supervisory authority must confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in Subsections (8)(c) and (d). (ix) Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis. (c) (i) The commissioner shall timely create and publish a list of reciprocal jurisdictions. (ii) (A) A list of reciprocal jurisdictions is published through the National Association of Insurance Commissioners' Committee Process. (B) The commissioner's list of reciprocal jurisdictions shall include any reciprocal jurisdiction as defined in this Subsection (8), and shall consider any other reciprocal jurisdictions in accordance with the criteria developed under rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. (iii) (A) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the commissioner shall not remove from the list a reciprocal jurisdiction. (B) Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed under this chapter. (d) (i) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this Subsection (8). (ii) The commissioner may add an assuming insurer to such list if a National Association of Insurance Commissioners accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the	

	commissioner as required under this Subsection (8) and complies with any additional requirements that the commissioner may impose by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except to the extent that they conflict with an applicable covered agreement. (e) (i) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this Subsection (8), the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this Subsection (8) in accordance with procedures established in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. (ii) (A) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with Subsection (10). (B) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Subsection (10). (f) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities. (g) Nothing in this Subsection (8) limits or in any way alters the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this chapter or other applicable law or regulation. (h) (i) Credit may be taken under this Subsection (8) only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this Subsection (8), and only with respect to losses incurred and reserves reported on or after the later of: (A) the date on which the assuming insurer has met all eligibility requirements pursuant to Subsection (8)(b); and (B) the effective date of the new reinsurance agreement, amendment or renewal. (ii) This Subsection (8) does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this Subsection (8), as long as the reinsurance qualifies for credit under any other applicable provision of this chapter.	

	(iii) Nothing in this Subsection (8) authorizes an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement. (iv) Nothing in this Subsection (8) limits, or in any way alters, the capacity of parties to any reinsurance agreement to renegotiate the agreement. (9) If reinsurance is ceded to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7), or (8), a domestic ceding insurer is allowed credit only as to the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law or regulation of that jurisdiction. (10) (a) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7), or (8) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer. (b) The commissioner may adopt by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specific additional requirements relating to or setting forth: (i) the valuation of assets or reserve credits; (ii) the amount and forms of security supporting reinsurance arrangements; and (iii) the circumstances pursuant to which credit will be reduced or eliminated. (c) (i) The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is: (A) held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or (B) in the case of a trust, held in a qualified United States financial institution. (ii) The security described in this Subsection (10)(c) may be in the form of: (A) cash; (B) securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets; (C) clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement; (D) letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent	

	failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or (E) any other form of security acceptable to the commissioner. (11[~~9~~]) Reinsurance credit may not be allowed a domestic ceding insurer unless the assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by: (a)(i) being an admitted insurer; and (ii) submitting to jurisdiction under Section 31A-2-309; (b) having irrevocably appointed the commissioner as the domestic ceding insurer's agent for service of process in an action arising out of or in connection with the reinsurance, which appointment is made under Section 31A-2-309; or (c) agreeing in the reinsurance contract: (i) that if the assuming insurer fails to perform its obligations under the terms of the reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall: (A) submit to the jurisdiction of a court of competent jurisdiction in a state of the United States; (B) comply with all requirements necessary to give the court jurisdiction; and (C) abide by the final decision of the court or of an appellate court in the event of an appeal; and (ii) to designate the commissioner or a specific attorney licensed to practice law in this state as its attorney upon whom may be served lawful process in an action, suit, or proceeding instituted by or on behalf of the ceding company. (1[~~0~~]2) Submitting to the jurisdiction of Utah courts under Subsection ([~~9~~]10) does not override a duty or right of a party under the reinsurance contract, including a requirement that the parties arbitrate their disputes. (1[~~1~~]3) If an assuming insurer does not meet the requirements of Subsection (3), (4), [~~or~~] (5) or (8), the credit permitted by Subsection (6) or ([~~8~~]7) may not be allowed unless the assuming insurer agrees in the trust instrument to the following conditions: (a)(i) Notwithstanding any other provision in the trust instrument, if an event described in Subsection (1[~~1~~]3)(a)(ii) occurs the trustee shall comply with: (A) an order of the commissioner with regulatory oversight over the trust; or (B) an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund. (ii) This Subsection (1[~~1~~])3(a) applies if: (A) the trust fund is inadequate because the trust contains an amount less than the amount required by Subsection (6)(d); or (B) the grantor of the trust is:	

	(I) declared insolvent; or (II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the laws of its state or country of domicile. (b) The assets of a trust fund described in Subsection (1[~~1~~]2)(a) shall be distributed by and a claim shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of a domestic insurance company. (c) If the commissioner with regulatory oversight determines that the assets of the trust fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust instrument. (d) A grantor shall waive any right otherwise available to it under United States law that is inconsistent with this Subsection (1[~~1~~]2). (1[~~2~~]3) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification. (a) The commissioner shall give the reinsurer notice and opportunity for hearing. (b) The suspension or revocation may not take effect until after the commissioner's order after a hearing, unless: (i) the reinsurer waives its right to hearing; (ii) the commissioner's order is based on: (A) regulatory action by the reinsurer's domiciliary jurisdiction; or (B) the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state under Subsection ([~~8~~]7)(g); or (iii) the commissioner's finding that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action. (c) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 31A-17-404.1. (d) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with Subsection ([~~8~~]7)(f) or Section 31A-17-404.1.	

	(1[~~3~~]4)(a) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. (b)(i) A domestic ceding insurer shall notify the commissioner within 30 days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers: (A) exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders; or (B) after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding insurer's last reported surplus to policyholders. (ii) The notification required by Subsection ([~~12~~]15)(b)(i) shall demonstrate that the exposure is safely managed by the domestic ceding insurer. (c) A ceding insurer shall take steps to diversify its reinsurance program. (d)(i) A domestic ceding insurer shall notify the commissioner within 30 days after ceding or being likely to cede more than 20% of the ceding insurer's gross written premium in the prior calendar year to any: (A) single assuming insurer; or (B) group of affiliated assuming insurers. (ii) The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.	
Lines	**Amendment text**	**Nature of change**
2989-3037	**31A-17-404.3. Rules.** (1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and this chapter, the commissioner may make rules prescribing: (a) the form of a letter of credit required under this chapter; (b) the requirements for a trust or trust instrument required by this chapter; (c) the procedures for licensing and accrediting; (d) minimum capital and surplus requirements; (e) additional requirements relating to calculation of credit allowed a domestic ceding insurer against reserves for reinsurance under Section 31A-17-404; and (f) additional requirements relating to calculation of asset reduction from liability for reinsurance ceded by a domestic insurer to other ceding insurers under Section 31A-17-404.1. (2) A rule made pursuant to Subsection (1)(e) or (f) may apply to reinsurance relating to: (a) a life insurance policy with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; (b) a universal life insurance policy with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;	***Policy change:*** The National Association of Insurance Commissioners ("NAIC"), the Federal Insurance Office ("FIO") and other agencies have negotiated with the U.K. and the European Union the terms of a law that allows insurance companies to receive credit for reinsurance ceded to international firms. The terms of the law are embodied in the amendments to Utah Code § 31A-17-404(8). Because of the difficulty of the negotiations, the NAIC and FIO recommend

	(c) a variable annuity with guaranteed death or living benefits; (d) a long-term care insurance policy; or (e) such other life and health insurance or annuity product as to which the National Association of Insurance Commissioners adopts model regulatory requirements with respect for credit for reinsurance. (3) A rule adopted pursuant to Subsection (1)(e) or (f) may apply to a treaty containing: (a) a policy issued on or after January 1, 2015; and (b) a policy issued before January 1, 2015, if risk pertaining to the policy is ceded in connection with the treaty, either in whole or in part, on or after January 1, 2015. (4) A rule adopted pursuant to Subsection (1)(e) or (f) may require the ceding insurer, in calculating the amounts or forms of security required to be held under rules made under this section, to use the Valuation Manual adopted by the National Association of Insurance Commissioners under Section 11B(1) of the National Association of Insurance Commissioners Standard Valuation Law, including all amendments adopted by the National Association of Insurance Commissioners and in effect on the date as of which the calculation is made, to the extent applicable. (5) A rule adopted pursuant to Subsection (1)(e) or (f) may not apply to cessions to an assuming insurer that: (a) Meets the conditions set forth in Section 31A-17-404(8); or ([~~a~~]b) is certified in this state [~~or, if this state has not adopted provisions substantially equivalent to Section 2E of the Credit for Reinsurance Model Law, certified in a minimum of five other states~~]; or ([~~b~~]c) maintains at least $250,000,000 in capital and surplus when determined in accordance with the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, including all amendments thereto adopted by the National Association of Insurance Commissioners, excluding the impact of any permitted or prescribed practices and is: (i) licensed in at least 26 states; or (ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states. (6) The authority to adopt rules pursuant to Subsection (1)(e) or (f) does not otherwise limit the commissioner's general authority to make rules pursuant to Subsection (1).	that the exact language of the law be adopted. States have until 10/1/22 to adopt the agreement in statute or face federal preemption. The Federal Insurance Office begins its preemption analysis on April 1, 2021. Accordingly, Utah should adopt the agreement during the 2020 legislative session.
Lines	**Amendment text**	**Nature of change**
3290-3302	**31A-22-205. Applicability of Restatement of the Law of Liability Insurance.** (1) As used in this section, "restatement" means the American Law Institute's Restatement of the Law of Liability Insurance. (2) The restatement is not the law or public policy of this state if the restatement is inconsistent or in conflict with or otherwise not addressed by:	***Policy Change:*** This legal publication holds itself as authoritative but contains statements on the law of liability insurance that

	(a) the Constitution of the United States; (b) the Utah Constitution; (c) a state statute; (d) state case law; or (e) state-adopted common law. (3) The restatement is not a source of Utah law. (4) A court may not apply or recognize the restatement as an authoritative reference regarding state liability insurance law.	represent unsound public policy. This statute establishes that the publication is not the law of this state.
Lines	**Amendment text**	**Nature of change**
3538-3726	**Part 20. Limited Long-Term Care Insurance Act** **31A-22-2001. Title.** This part is known as the "Limited Long-Term Care Insurance Act." **31A-22-2002. Definitions.** As used in this part: (1) "Applicant" means: (a) when referring to an individual limited long-term care insurance policy, the person who seeks to contract for benefits; and (b) when referring to a group limited long-term care insurance policy, the proposed certificate holder. (2) "Elimination period" means the length of time between meeting the eligibility for benefit payment and receiving benefit payments from an insurer. (3) "Group limited long-term care insurance" means a limited long-term care insurance policy that is delivered or issued for delivery: (a) in this state; and (b) to an eligible group, as described under Subsection 31A-22-701(2). (4) (a) "Limited long-term care insurance" means an insurance: (i) policy, endorsement, or rider that is advertised, marketed, offered, or designed to provide coverage: (A) for less than 12 consecutive months for each covered person; (B) on an expense-incurred, indemnity, prepaid or other basis; and (C) for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services that is provided in a setting other than an acute care unit of a hospital; or	***Policy change:*** Utah does not currently have a law that specifically governs limited long-term care ("LLTC") insurance. At least one Utah-licensed company has expressed an interest in offering this insurance product. The proposed amendment fills this void in Utah law by setting disclosure and performance standards for LLTC insurance, by setting an incontestability period, and by providing for nonforfeiture of benefits. The amendment is based on the National Association of Insurance Commissioners' Limited Long-Term Care Insurance Model Act.

	(ii) policy or rider that provides for payment of benefits based on cognitive impairment or the loss of functional capacity. (b) "Limited long-term care insurance" does not include an insurance policy that is offered primarily to provide: (i) basic Medicare supplement coverage; (ii) basic hospital expense coverage; (iii) basic medical-surgical expense coverage; (iv) hospital confinement indemnity coverage; (v) major medical expense coverage; (vi) disability income or related asset-protection coverage; (vii) accidental only coverage; (viii) specified disease or specified accident coverage; or (ix) limited benefit health coverage. (5) "Preexisting condition" means a condition for which medical advice or treatment is recommended: (a) by, or received from, a provider of health care services; and (b) within six months before the day on which the coverage of an insured person becomes effective. (6) "Waiting period" means the time an insured waits before some or all of the insured's coverage becomes effective. **31A-22-2003. Scope.** (1) The requirements of this part apply to limited long-term care insurance policies and certificates marketed, delivered, or issued for delivery in this state on or after July 1, 2020. (2) Laws and regulations designed or intended to apply to Medicare supplement insurance policies may not be applied to limited long-term care insurance. **31A-22-2004. Disclosure and performance standards for limited long-term care insurance.** (1) A limited long-term care insurance policy may not: (a) be cancelled, nonrenewed, or otherwise terminated because of the age, gender, or the deterioration of the mental or physical health of the insured individual or certificate holder; (b) contain a provision establishing a new waiting period if existing coverage is converted to or replaced by a new or other form within the same insurer, or the insurer's affiliates, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or (c) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.	

	(2) (a) A limited long-term care insurance policy or certificate may not: (i) use a definition of "preexisting condition" that is more restrictive than the definition under this part; or (ii) exclude coverage for a loss or confinement that is the result of a preexisting condition, unless the loss or confinement begins within six months after the day on which the coverage of the insured person becomes effective. (b) A preexisting condition does not prohibit an insurer from: (i) using an application form designed to elicit the complete health history of an applicant; or (ii) on the basis of the answers on the application described in Subsection (2)(c)(i), underwriting in accordance with the insurer's established underwriting standards. (c) (i) Unless otherwise provided in the policy or certificate, an insurer may exclude coverage of a preexisting condition: (A) for a time period of six months, beginning the day on which the coverage of the insured person becomes effective; and (B) regardless of whether the preexisting condition is disclosed on the application. (ii) A limited long-term care insurance policy or certificate may not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions for more than a time period of six months, beginning the day on which the coverage of the insured person becomes effective. (3) (a) An insurer may not deliver or issue for delivery a limited long-term care insurance policy that conditions eligibility for any benefits: (i) on a prior hospitalization requirement; (ii) provided in an institutional care setting, on the receipt of a higher level of institutional care; or (iii) other than waiver of premium, post-confinement, post-acute care, or recuperative benefits, on a prior institutionalization requirement. (b) A limited long-term care insurance policy or rider may not condition eligibility for noninstitutional benefits on the prior or continuing receipt of skilled care services. (4) (a) If, after examination of a policy, certificate, or rider, a limited long-term care insurance applicant is not satisfied for any reason, the applicant has the right to: (i) within 30 days after the day on which the applicant receives the policy, certificate, endorsement, or rider, return the policy, certificate, endorsement, or rider to the company or a producer of the company; and (ii) have the premium refunded. (b) (i) Each limited long-term care insurance policy, certificate, endorsement, and rider shall:	

	(A) have a notice prominently printed on the first page or attached thereto detailing specific instructions to accomplish a return; and (B) include the following free-look statement or language substantially similar: "You have 30 days from the day on which you receive this policy certificate, endorsement, or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office. Or you may return it to the producer that you bought it from. You must return it within 30 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy certificate or rider will be void as if it had never been issued." (ii) The requirements described in Subsection (4)(b)(i) do not apply to a certificate issued to an employee under an employer group limited long-term care insurance policy. (5) (a) (i) An insurer shall deliver an outline of coverage to a prospective applicant for limited long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and the document's purpose. (ii) In the case of an agent solicitation, the agent shall deliver the outline of coverage before the presentation of an application or enrollment form. (iii) In the case of a direct response solicitation, the outline of coverage shall be presented in conjunction with any application or enrollment form. (iv) (A) In the case of a policy issued to a group, the outline of coverage is not required to be delivered if the information described in Subsections (5)(b)(i) through (iii) is contained in other materials relating to enrollment, including the certificate. (B) Upon request, an insurer shall make the other materials described in this Subsection (5)(a)(iv) available to the commissioner. (b) An outline of coverage shall include: (i) a description of the principal benefits and coverage provided in the policy; (ii) a description of the eligibility triggers for benefits and how the eligibility triggers are met; (iii) a statement of the principal exclusions, reductions, and limitations contained in the policy; (iv) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. (v) a specific description of each continuation or conversion provision of group coverage; (vi) a statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;	

	(vii) a description of the terms under which a person may return the policy or certificate and have the premium refunded; (viii) a brief description of the relationship of cost of care and benefits; and (ix) a statement that discloses to the policyholder or certificate holder that the policy is not long-term care insurance. (6) A certificate pursuant to a group limited long-term care insurance policy that is delivered or issued for delivery in this state shall include: (a) a description of the principal benefits and coverage provided in the policy; (b) a statement of the principal exclusions, reductions, and limitations contained in the policy; and (c) a statement that the group master policy determines governing contractual provisions. (7) If an application for a limited long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later that 30 days after the day on which the application is approved. **31A-22-2005. Nonforfeiture benefits.** (1) (a) A limited long-term care insurance policy may offer the option of purchasing a policy or certificate including a nonforfeiture benefit. (b) The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. (c) In the event the policy holder or certificate holder does not purchase a nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates. (2) If an insurer issues a group limited long-term care insurance policy, the insurer shall: (a) make any offer of a nonforfeiture benefit to the group policyholder; and (b) make any offer to each proposed certificate holder. **31A-22-2006. Rulemaking.** In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner: (1) shall makes rules: (a) in the event of a substantial rate increase, promoting premium adequacy and protecting the policy holder; (b) establishing minimum standards for limited long-term care insurance marketing practices, producer compensation, producer testing, independent review of benefit determinations, penalties, and reporting practices; (c) prescribing a standard format, including style, arrangement, and overall appearance of an outline of coverage;	

	(d) prescribing the content of an outline of coverage, in accordance with the requirements described in Subsection 31A-22-2004(5)(b); (e) specifying the type of nonforfeiture benefits offered as part of a limited long-term care insurance policy or certificate; (f) establishing the standards of nonforfeiture benefits; and (g) establishing the rules regarding contingent benefits upon lapse, including: (i) a determination of the specified period of time during which a contingent benefit upon lapse will be available; and (ii) the substantial premium rate increase that triggers a contingent benefit upon lapse as described in Subsection 31A-22-2005(1); and (2) may make rules establishing loss-ratio standards for limited long-term care insurance policies.	
Lines	**Amendment text**	**Nature of change**
3906- 3987	**31A-23a-415. Assessment on agency title insurance producers or title insurers -- Account created.** (1) For purposes of this section: (a) "Premium" is as ~~defined~~ described in Subsection 59-9-101(3). (b) "Title insurer" means a person: (i) making any contract or policy of title insurance as: (A) insurer; (B) guarantor; or (C) surety; (ii) proposing to make any contract or policy of title insurance as: (A) insurer; (B) guarantor; or (C) surety; or (iii) transacting or proposing to transact any phase of title insurance, including: (A) soliciting; (B) negotiating preliminary to execution; (C) executing of a contract of title insurance; (D) insuring; and (E) transacting matters subsequent to the execution of the contract and arising out of the contract. (c) "Utah risks" means insuring, guaranteeing, or indemnifying with regard to real or personal property located in Utah, an owner of real or personal property, the holders of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of:	

	(i) liens or encumbrances upon, defects in, or the unmarketability of the title to the property; or (ii) invalidity or unenforceability of any liens or encumbrances on the property. (2)(a) The commissioner may assess each title insurer, each individual title insurance producer who is not an employee of a title insurer or who is not designated by an agency title insurance producer, and each agency title insurance producer an annual assessment: (i) determined by the Title and Escrow Commission: (A) after consultation with the commissioner; and (B) in accordance with this Subsection (2); and (ii) to be used for the purposes described in Subsection (3). (b) An agency title insurance producer and individual title insurance producer who is not an employee of a title insurer or who is not designated by an agency title insurance producer shall be assessed up to: (i) $250 for the first office in each county in which the agency title insurance producer or individual title insurance producer maintains an office; and (ii) $150 for each additional office the agency title insurance producer or individual title insurance producer maintains in the county described in Subsection (2)(b)(i). (c) A title insurer shall be assessed up to: (i) $250 for the first office in each county in which the title insurer maintains an office; (ii) $150 for each additional office the title insurer maintains in the county described in Subsection (2)(c)(i); and (iii) an amount calculated by: (A) aggregating the assessments imposed on: (I) agency title insurance producers and individual title insurance producers under Subsection (2)(b); and (II) title insurers under Subsections (2)(c)(i) and (2)(c)(ii); (B) subtracting the amount determined under Subsection (2)(c)(iii)(A) from the total costs and expenses determined under Subsection (2)(d); and (C) multiplying: (I) the amount calculated under Subsection (2)(c)(iii)(B); and (II) the percentage of total premiums for title insurance on Utah risk that are premiums of the title insurer. (d) Notwithstanding Section 31A-3-103 and subject to Section 31A-2-404, the Title and Escrow Commission by rule shall establish the amount of costs and expenses described under Subsection (3)	

	that will be covered by the assessment, except the costs or expenses to be covered by the assessment may not exceed ~~[$100,000 annually~~] the cost of one full-time equivalent position. (e)(i) An individual licensed to practice law in Utah is exempt from the requirements of this Subsection (2) if that person issues 12 or less policies during a 12-month period. (ii) In determining the number of policies issued by an individual licensed to practice law in Utah for purposes of Subsection (2)(e)(i), if the individual issues a policy to more than one party to the same closing, the individual is considered to have issued only one policy. (3)(a) Money received by the state under this section shall be deposited into the Title Licensee Enforcement Restricted Account. (b) There is created in the General Fund a restricted account known as the "Title Licensee Enforcement Restricted Account." (c) The Title Licensee Enforcement Restricted Account shall consist of the money received by the state under this section. (d) The commissioner shall administer the Title Licensee Enforcement Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Title Licensee Enforcement Restricted Account only to pay for a cost or expense incurred by the department in the administration, investigation, and enforcement of laws governing individual title insurance producers, agency title insurance producers, or title insurers. (e) An appropriation from the Title Licensee Enforcement Restricted Account is nonlapsing. (4) The assessment imposed by this section shall be in addition to any premium assessment imposed under Subsection 59-9-101(3).	***Policy change:*** The current statute caps recoverable title enforcement costs at $100,000. However, Utah's budget statute now authorizes the Department to spend up to $131,200 for that work. (General Session 2019, House Bill 4, Item 88.) Because the budget statute is updated annually and reflects the legislature's current intent on spending limits, it is unnecessary to maintain a statutory cap in the Insurance Code. However, intends to limit enforcement expenditures to the amount of one FTE which currently exceed $100,000.
Lines	**Amendment text**	**Nature of change**
4510- 4700	**31A-26-301.6. Health care claims practices.** (1) As used in this section: ~~[(a) "Articulable reason" may include a determination regarding:~~] ~~[(i) eligibility for coverage;]~~ ~~[(ii) preexisting conditions;]~~ ~~[(iii) applicability of other public or private insurance;]~~ ~~[(iv) medical necessity; and]~~ ~~[(v) any other reason that would justify an extension of the time to investigate a claim.]~~ ~~[(b)~~] (a) "Health care provider" means a person licensed to provide health care under: (i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or (ii) Title 58, Occupations and Professions.	

	~~[(c)]~~ (b) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes: (i) a health maintenance organization; and (ii) a third party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims. ~~[(d)]~~ (c) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of: (i) an agreement between the insurer and the provider; (ii) a health insurance policy or contract of the insurer; or (iii) state or federal law. (2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section. (3) (a) Except as provided in Subsection (4), within 30 days of the day on which the insurer receives a written claim, an insurer shall: (i) pay the claim; or (ii) deny the claim and provide a written explanation for the denial. (b) (i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a) may be extended by 15 days if the insurer: (A) determines that the extension is necessary due to matters beyond the control of the insurer; and (B) before the end of the 30-day period described in Subsection (3)(a), notifies the provider and insured in writing of: (I) the circumstances requiring the extension of time; and (II) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial. (ii) If an extension is necessary due to a failure of the provider or insured to submit the information necessary to decide the claim: (A) the notice of extension required by this Subsection (3)(b) shall specifically describe the required information; and (B) the insurer shall give the provider or insured at least 45 days from the day on which the provider or insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (3)(b)(ii)(A).	

	(4) (a) In the case of a claim for income replacement benefits, within 45 days of the day on which the insurer receives a written claim, an insurer shall: (i) pay the claim; or (ii) deny the claim and provide a written explanation of the denial. (b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a) may be extended for 30 days if the insurer: (i) determines that the extension is necessary due to matters beyond the control of the insurer; and (ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies the insured of: (A) the circumstances requiring the extension of time; and (B) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial. (c) Subject to Subsections (4)(d) and (e), the time period for complying with Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the 30-day extension period provided in Subsection (4)(b) ends if before the day on which the 30-day extension period ends, the insurer: (i) determines that due to matters beyond the control of the insurer a decision cannot be rendered within the 30-day extension period; and (ii) notifies the insured of: (A) the circumstances requiring the extension; and (B) the date as of which the insurer expects to pay the claim or deny the claim with a written explanation for the denial. (d) A notice of extension under this Subsection (4) shall specifically explain: (i) the standards on which entitlement to a benefit is based; and (ii) the unresolved issues that prevent a decision on the claim. (e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of the insured to submit the information necessary to decide the claim: (i) the notice of extension required by Subsection (4)(b) or (c) shall specifically describe the necessary information; and (ii) the insurer shall give the insured at least 45 days from the day on which the insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (4)(b) or (c). (5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or (4)(c), due to an insured or provider failing to submit information necessary to decide a claim, the period for making	

	the benefit determination shall be tolled from the date on which the notification of the extension is sent to the insured or provider until the date on which the insured or provider responds to the request for additional information. (6) An insurer shall pay all sums to the provider or insured that the insurer is obligated to pay on the claim, and provide a written explanation of the insurer's decision regarding any part of the claim that is denied within 20 days of receiving the information requested under Subsection (3)(b), (4)(b), or (4)(c). (7) (a) Whenever an insurer makes a payment to a provider on any part of a claim under this section, the insurer shall also send to the insured an explanation of benefits paid. (b) Whenever an insurer denies any part of a claim under this section, the insurer shall also send to the insured: (i) a written explanation of the part of the claim that was denied; and (ii) notice of the adverse benefit determination review process established under Section 31A-22-629. (c) This Subsection (7) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or federal law. (8) (a) [~~Beginning with health care claims submitted on or after January 1, 2002, a~~] A late fee shall be imposed on: (i) an insurer that fails to timely pay a claim in accordance with this section; and (ii) a provider that fails to timely provide information on a claim in accordance with this section. (b) For the first 90 days that a claim payment or a provider response to a request for information is late, the late fee shall be determined by multiplying together: (i) the total amount of the claim the insurer is obliged to pay; (ii) the total number of days the response or the payment is late; and (iii) .1%. (c) For a claim payment or a provider response to a request for information that is 91 or more days late, the late fee shall be determined by adding together: (i) the late fee for a 90-day period under Subsection (8)(b); and (ii) the following multiplied together: (A) the total amount of the claim the insurer is obliged to pay; (B) the total number of days the response or payment was late beyond the initial 90-day period; and (C) the rate of interest set in accordance with Section 15-1-1. (d) Any late fee paid or collected under this section shall be separately identified on the documentation used by the insurer to pay the claim.	

	(e) For purposes of this Subsection (8), "late fee" does not include an amount that is less than $1. (9) Each insurer shall establish a review process to resolve claims-related disputes between the insurer and providers. (10) An insurer or person representing an insurer may not engage in any unfair claim settlement practice with respect to a provider. Unfair claim settlement practices include: (a) knowingly misrepresenting a material fact or the contents of an insurance policy in connection with a claim; (b) failing to acknowledge and substantively respond within 15 days to any written communication from a provider relating to a pending claim; (c) denying or threatening to deny the payment of a claim for any reason that is not clearly described in the insured's policy; (d) failing to maintain a payment process sufficient to comply with this section; (e) failing to maintain claims documentation sufficient to demonstrate compliance with this section; (f) failing, upon request, to give to the provider written information regarding the specific rate and terms under which the provider will be paid for health care services; (g) failing to timely pay a valid claim in accordance with this section as a means of influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual relationship; (h) failing to pay the sum when required and as required under Subsection (8) when a violation has occurred; (i) threatening to retaliate or actual retaliation against a provider for the provider applying this section; (j) any material violation of this section; and (k) any other unfair claim settlement practice established in rule or law. (11) (a) The provisions of this section shall apply to each contract between an insurer and a provider for the duration of the contract. (b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad faith insurance claim. (c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer and a provider from including provisions in their contract that are more stringent than the provisions of this section. (12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, [~~and beginning January 1, 2002,~~] the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.	

	(b) The commissioner may adopt rules only as necessary to implement this section. (c) The commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received. (d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules regarding the review process required by Subsection (9). (13) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5. (14) Nothing in this section may be construed as limiting the ability of an insurer to: (a) recover any amount improperly paid to a provider or an insured: (i) in accordance with Section 31A-31-103 or any other provision of state or federal law; (ii) within 24 months of the amount improperly paid for a coordination of benefits error; (iii) within 12 months of the amount improperly paid for any other reason not identified in Subsection (14)(a)(i) or (ii); or (iv) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program; (b) take any action against a provider that is permitted under the terms of the provider contract and not prohibited by this section; (c) report the provider to a state or federal agency with regulatory authority over the provider for unprofessional, unlawful, or fraudulent conduct; or (d) enter into a mutual agreement with a provider to resolve alleged violations of this section through mediation or binding arbitration. (15) A health care provider may only seek recovery from the insurer for an amount improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b). <u>(16) (a) (i) An insurer shall remit in full the payment the insurer is obligated to pay to the health care provider or insured.</u> <u>(ii) The insurer's payment under this Subsection (16)(a) may not be reduced for fees incurred for the method of payment, regardless of the payment method.</u> <u>(b) An insurer may offer the remittance of payment through a credit card or other similar arrangement, if the health care provider or insured:</u> <u>(i) is not charged a fee; and</u> <u>(ii) voluntarily elects to receive remittance through a prepaid credit card or other similar arrangement.</u>	***Policy Change:*** Prohibits insurers from requiring an insured or provider to receive payment of benefits through a prepaid credit card or similar arrangements.

	(c) An insurer may not require a health care provider or insured to accept remittance through a credit card or other similar arrangement.	
Lines	**Amendment text**	**Nature of change**
4953- 4969	**31A-37-303. Reinsurance.** (1) A captive insurance company may cede risks to any insurance company approved by the commissioner. A captive insurance company may provide reinsurance, as authorized in this title, on risks ceded ~~for the benefit of a parent, affiliate, or controlled unaffiliated business~~ by any other insurer with prior approval of the commissioner.	***Policy change:*** The amendment reflects an industry development in which captive insurer to reinsure the risks of other insurers. The development was motivated by the IRS's recently- announced position that captives must spread risks like typical insurers in order to receive certain tax benefits. The amendment reflects a conservative approach by requiring the commissioner to approve reinsurance.
Lines	**Amendment text**	**Nature of change**
5091- 5257	**63A-5-205.5. Health insurance requirements -- Penalties.** (1) As used in this section: (a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project. (b) "Change order" means the same as that term is defined in Section 63G-6a-103. (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who: (i) works at least 30 hours per calendar week; and (ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days after the day on which the individual is hired. (d) "Health benefit plan" means: (i) the same as that term is defined in Section 31A-1-301[~~.~~]; or (ii) an employee welfare benefit plan: (A) established under the Employee Retirement Income Security Act of 1974, 29U.S.C. Sec. 1001 et seq.;	***Policy Change:*** Expands an allowable health plan to

	(B) for an employer with 100 or more employees; and (C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees. (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in section 26-40-115. (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208. (g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301. (2) Except as provided in Subsection (3), the requirements of this section apply to: (a) a contractor of a design or construction contract entered into by the division or the State Building Board on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and (b) a subcontractor of a contractor of a design or construction contract entered into by the division or State Building Board on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000. (3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if: (a) the application of this section jeopardizes the receipt of federal funds; (b) the contract is a sole source contract; or (c) the contract is an emergency procurement. (4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction. (5) (a) A contractor that is subject to the requirements of this section shall demonstrate to the director that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employees' dependents by submitting to the director a written statement that: (i) the contractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115; (ii) is from: (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~] (B) an underwriter who is responsible for developing the employer group's premium rates; [~~and~~] or (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by a third party administrator; and (iii) was created within one year before the day on which the statement is submitted. (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide	include a self-funded employer with 100 or more employees. ***Policy Change:*** Allows a contractor to use a third-party administrator's actuary or underwriter to demonstrate

	the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the actuarial value of the health benefit plan meet the requirements of qualified health coverage. (ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to: (A) the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and (B) the division. [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall: (i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and (ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that: (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115; (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and (C) was created within one year before the day on which the contractor obtains the statement. [~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6). (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i). (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6). (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).	compliance with offering and maintaining a qualified health plan.

	(6) The division shall adopt administrative rules: (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; (b) in coordination with: (i) the Department of Environmental Quality in accordance with Section 19-1-206; (ii) the Department of Natural Resources in accordance with Section 79-2-404; (iii) a public transit district in accordance with Section 17B-2a-818.5; (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; (v) the Department of Transportation in accordance with Section 72-6-107.5; and (vi) the Legislature's Administrative Rules Review Committee; and (c) that establish: (i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including: (A) that a contractor or subcontractor's compliance with this section is subject to an audit by the division or the Office of the Legislative Auditor General; (B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and (C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[~~(b)~~](c)(ii); (ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include: (A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation; (B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation; (C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and (D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [~~insurance~~] coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health [~~insurance~~] coverage during the duration of the contract; and (iii) a website on which the department shall post the commercially equivalent benchmark for the qualified health [~~insurance~~] coverage that is provided by the Department of Health in accordance with Subsection 26-40-115(2). (7) (a) During the duration of a contract, the division may perform an audit to verify a contractor or	

	subcontractor's compliance with this section. (b) Upon the division's request, a contractor or subcontractor shall provide the division: (i) a signed actuarial certification that the coverage the contractor or subcontractor offers is qualified health [~~insurance~~] coverage; or (ii) all relevant documents and information necessary for the division to determine compliance with this section. (c) If a contractor or subcontractor provides the documents and information described in Subsection (7)(b)(ii), the Insurance Department shall assist the division in determining if the coverage the contractor or subcontractor offers is qualified health [~~insurance~~] coverage. (8) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor that intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage. (ii) An employer has an affirmative defense to a cause of action under Subsection (8)(a) if: (A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)[~~(b)~~](c)(ii); or (B) the department determines that compliance with this section is not required under the provisions of Subsection (3). (b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (8). (9) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created by Section 26-18-402. (10) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~] coverage as required by this section: (a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under: (i) Section 63G-6a-1602; or (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and (b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction. (11) An administrator, including an administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in Subsection (1)(d)(ii): (a) subject to Subsection (11)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement;	***Policy Change:*** Provides that an administrator's actuary or underwriter is not liable for information provided in good

	(b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and (c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.	faith regarding a contractor's qualified health plan.
Lines	**Amendment text**	**Nature of change**
5259- 5415	**63C-9-403. Contracting power of executive director -- Health insurance coverage.** (1) As used in this section: (a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project. (b) "Change order" means the same as that term is defined in Section 63G-6a-103. (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who: (i) works at least 30 hours per calendar week; and (ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first of the calendar month following 60 days after the day on which the individual is hired. (d) "Health benefit plan" means: (i) the same as that term is defined in Section 31A-1-301[.]; or (ii) an employee welfare benefit plan: (A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.; (B) for an employer with 100 or more employees; and (C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees. (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in Section 26-40-115. (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208. (g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301. (2) Except as provided in Subsection (3), the requirements of this section apply to: (a) a contractor of a design or construction contract entered into by the board, or on behalf of the board, on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and (b) a subcontractor of a contractor of a design or construction contract entered into by the board, or on behalf of the board, on or after July 1, 2009, if the subcontract is in an aggregate amount equal	***Policy Change:*** Expands an allowable health plan to include a self-funded employer with 100 or more employees.

	to or greater than $1,000,000. (3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if: (a) the application of this section jeopardizes the receipt of federal funds; (b) the contract is a sole source contract; or (c) the contract is an emergency procurement. (4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction. (5) (a) A contractor subject to the requirements of this section shall demonstrate to the executive director that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the duration of the contract by submitting to the executive director a written statement that: (i) the contractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115; (ii) is from: (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~] (B) an underwriter who is responsible for developing the employer group's premium rates; [~~and~~] or (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by a third party administrator; and (iii) was created within one year before the day on which the statement is submitted. (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide the actuary or underwriter selected by the administrator, as described in Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the health benefit plan's actuarial value meets the requirements of qualified health coverage. (ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to: (A) the actuary or underwriter selected by the administrator, as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and (B) the executive director. [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall: (i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and	***Policy Change:*** Allows a contractor to use a third-party administrator's actuary or underwriter to demonstrate compliance with offering and maintaining a qualified health plan.

	(ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that: (A) the subcontractor offers qualified health [insurance] coverage that complies with Section 26-40-115; (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and (C) was created within one year before the day on which the contractor obtains the statement. [~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [~~insurance~~] coverage as described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6). (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i). (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6). (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a). (6) The department shall adopt administrative rules: (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; (b) in coordination with: (i) the Department of Environmental Quality in accordance with Section 19-1-206; (ii) the Department of Natural Resources in accordance with Section 79-2-404; (iii) the State Building Board in accordance with Section 63A-5-205.5; (iv) a public transit district in accordance with Section 17B-2a-818.5; (v) the Department of Transportation in accordance with Section 72-6-107.5; and (vi) the Legislature's Administrative Rules Review Committee; and (c) that establish: (i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including: (A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General; (B) that a contractor that is subject to the requirements of this section shall obtain a written	

	statement described in Subsection (5)(a); and (C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[~~(b)~~](c)(ii); (ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include: (A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation; (B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation; (C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and (D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [~~insurance~~] coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health [~~insurance~~] coverage during the duration of the contract; and (iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health [insurance] coverage identified in Subsection (1)(e), that is provided by the Department of Health, in accordance with Subsection 26-40-115(2). (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage. (ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if: (A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)[~~(b)~~](c)(ii); or (B) the department determines that compliance with this section is not required under the provisions of Subsection (3). (b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7). (8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402. (9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~] coverage as required by this section: (a) may not be the basis for a protest or other action from a prospective bidder, offeror, or	

	contractor under: (i) Section 63G-6a-1602; or (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and (b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction. (10) An administrator, including the administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in Subsection (1)(d)(ii): (a) subject to Subsection (10)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement; (b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and (c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.	***Policy Change:*** Provides that an administrator's actuary or underwriter is not liable for information provided in good faith regarding a contractor's qualified health plan.
Lines	**Amendment text**	**Nature of change**
5417- 5574	**72-6-107.5. Construction of improvements of highway -- Contracts – Health insurance coverage.** (1) As used in this section: (a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project. (b) "Change order" means the same as that term is defined in Section 63G-6a-103. (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who: (i) works at least 30 hours per calendar week; and (ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days after the day on which the individual is hired. (d) "Health benefit plan" means: (i) the same as that term is defined in Section 31A-1-301[~~,~~]; or (ii) an employee welfare benefit plan: (A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.; (B) for an employer with 100 or more employees; and (C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees.	***Policy Change:*** Expands an allowable health plan to include a self-funded employer with 100 or more employees.

	(e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in Section 26-40-115. (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208. (g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301. (2) Except as provided in Subsection (3), the requirements of this section apply to: (a) a contractor of a design or construction contract entered into by the department on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and (b) a subcontractor of a contractor of a design or construction contract entered into by the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000. (3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if: (a) the application of this section jeopardizes the receipt of federal funds; (b) the contract is a sole source contract; or (c) the contract is an emergency procurement. (4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction. (5) (a) A contractor subject to the requirements of this section shall demonstrate to the department that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the duration of the contract by submitting to the department a written statement that: (i) the contractor offers qualified health [insurance] coverage that complies with Section 26-40-115; (ii) is from: (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~] (B) an underwriter who is responsible for developing the employer group's premium rates; [~~and~~] or (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by a third party administrator; and (iii) was created within one year before the day on which the statement is submitted. (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the actuarial value of the health benefit plan meet the requirements of qualified health coverage.	***Policy Change*:** Allows a contractor to use a third-party administrator's actuary or underwriter to demonstrate compliance with offering and maintaining a qualified health plan.

	(ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to: (A) the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and (B) the department. [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall: (i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and (ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that: (A) the subcontractor offers qualified health [insurance] coverage that complies with Section 26-40-115; (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and (C) was created within one year before the day on which the contractor obtains the statement. [~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6). (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i). (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6). (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [insurance] coverage described in Subsection (5)(a). (6) The department shall adopt administrative rules: (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act: (b) in coordination with: (i) the Department of Environmental Quality in accordance with Section 19-1-206;	

	(ii) the Department of Natural Resources in accordance with Section 79-2-404; (iii) the State Building Board in accordance with Section 63A-5-205.5; (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; (v) a public transit district in accordance with Section 17B-2a-818.5; and (vi) the Legislature's Administrative Rules Review Committee; and (c) that establish: (i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including: (A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General; (B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and (C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[~~(b)~~](c)(ii); (ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include: (A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation; (B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation; (C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and (D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [~~insurance~~] coverage for an employee and a dependent of the employee of the contractor or subcontractor who was not offered qualified health [~~insurance~~] coverage during the duration of the contract; and (iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is provided by the Department of Health, in accordance with Subsection 26-40-115(2). (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage. (ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if: (A) the employer relied in good faith on a written statement described in Subsection (5)(a) or	

	(5)[(b)](c)(ii); or (B) the department determines that compliance with this section is not required under the provisions of Subsection (3). (b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7). (8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402. (9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~] coverage as required by this section: (a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under: (i) Section 63G-6a-1602; or (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and (b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction. (10) An administrator, including an administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in Subsection (1)(d)(ii): (a) subject to Subsection (10)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement; (b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and (c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.	***Policy Change:*** Provides that an administrator's actuary or underwriter is not liable for information provided in good faith regarding a contractor's qualified health plan.
Lines	**Amendment text**	**Nature of change**
5576- 5742	**79-2-404. Contracting powers of department -- Health insurance coverage.** (1) As used in this section: (a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project. (b) "Change order" means the same as that term is defined in Section 63G-6a-103. (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who: (i) works at least 30 hours per calendar week; and (ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed	

	the first day of the calendar month following 60 days after the day on which the individual is hired. (d) "Health benefit plan" means: (i) the same as that term is defined in Section 31A-1-301[.]; or (ii) an employee welfare benefit plan: (A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.; (B) for an employer with 100 or more employees; and (C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees. (e) "Qualified health [insurance] coverage" means the same as that term is defined in Section 26-40-115. (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208. (g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301. (2) Except as provided in Subsection (3), the requirements of this section apply to: (a) a contractor of a design or construction contract entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and (b) a subcontractor of a contractor of a design or construction contract entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000. (3) This section does not apply to contracts entered into by the department or a division, board, or council of the department if: (a) the application of this section jeopardizes the receipt of federal funds; (b) the contract or agreement is between: (i) the department or a division, board, or council of the department; and (ii) (A) another agency of the state; (B) the federal government; (C) another state; (D) an interstate agency; (E) a political subdivision of this state; or (F) a political subdivision of another state; or (c) the contract or agreement is: (i) for the purpose of disbursing grants or loans authorized by statute;	***Policy Change:*** Expands an allowable health plan to include a self-funded employer with 100 or more employees.

	(ii) a sole source contract; or (iii) an emergency procurement. (4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction. (5) (a) A contractor subject to the requirements of this section shall demonstrate to the department that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the duration of the contract by submitting to the department a written statement that: (i) the contractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115; (ii) is from: (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~] (B) an underwriter who is responsible for developing the employer group's premium rates; [~~and~~] or (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by a third party administrator; and (iii) was created within one year before the day on which the statement is submitted. (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the actuarial value of the health benefit plan meet the requirements of qualified health coverage. (ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to: (A) the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and (B) the department. [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall: (i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and (ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that: (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-	***Policy Change:*** Allows a contractor to use a third-party administrator's actuary or underwriter to demonstrate compliance with offering and maintaining a qualified health plan.

	115; (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and (C) was created within one year before the day on which the contractor obtains the statement. [~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6). (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i). (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6). (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a). (6) The department shall adopt administrative rules: (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; (b) in coordination with: (i) the Department of Environmental Quality in accordance with Section 19-1-206; (ii) a public transit district in accordance with Section 17B-2a-818.5; (iii) the State Building Board in accordance with Section 63A-5-205.5; (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; (v) the Department of Transportation in accordance with Section 72-6-107.5; and (vi) the Legislature's Administrative Rules Review Committee; and (c) that establish: (i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including: (A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General; (B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and (C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[~~(b)~~](c)(ii);	

	(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include: (A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation; (B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation; (C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and (D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [~~insurance~~] coverage for an employee and a dependent of an employee of the contractor or subcontractor who was not offered qualified health [~~insurance~~] coverage during the duration of the contract; and (iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), provided by the Department of Health, in accordance with Subsection 26-40-115(2). (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage. (ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if: (A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)[~~(b)~~](c)(ii); or (B) the department determines that compliance with this section is not required under the provisions of Subsection (3). (b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7). (8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402. (9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~] coverage as required by this section: (a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under: (i) Section 63G-6a-1602; or (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and (b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a	

	basis for any action or suit that would suspend, disrupt, or terminate the design or construction. (10) An administrator, including an administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in Subsection (1)(d)(ii): (a) subject to Subsection (10)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement; (b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and (c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.	***Policy Change:*** Provides that an administrator's actuary or underwriter is not liable for information provided in good faith regarding a contractor's qualified health plan.