Utah Insurance Department
2021 Legislative Session
Statement and description of the Utah Insurance Department's proposed amendments

Technical change: *Formatting, numbering, word order or language changes only*
Codifies practice: *Changed language, but no change in practice*
Policy Change: *New language and new practice*

Lines	Amendment text	Nature of change
142-176	**31A-1-103. Scope and applicability of title.** ***** (3) Except as otherwise expressly provided, this title does not apply to: (a) those activities of an insurer where state jurisdiction is preempted by Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended; (b) ocean marine insurance; (c) death, accident, health, or disability benefits provided by an organization if the organization: (i) has as the organization's principal purpose to achieve charitable, educational, social, or religious objectives rather than to provide death, accident, health, or disability benefits; (ii) does not incur a legal obligation to pay a specified amount; and (iii) does not create reasonable expectations of receiving a specified amount on the part of an insured person; (d) other business specified in rules adopted by the commissioner on a finding that: (i) the transaction of the business in this state does not require regulation for the protection of the interests of the residents of this state; or (ii) it would be impracticable to require compliance with this title; (e) except as provided in Subsection (4), a transaction independently procured through negotiations under Section 31A-15-104; (f) self-insurance; (g) reinsurance; (h) subject to Subsection (5), an employee [~~and~~] or labor union group [~~or~~] insurance policy covering risks in this state or an employee or labor union blanket insurance policy covering risks in this state if: (i) the policyholder exists primarily for purposes other than to procure insurance; (ii) the policyholder:	***Technical change:*** Corrects references to defined term 'blanket insurance policy' as defined in 31A-1-301.

	(A) is not a resident of this state; (B) is not a domestic corporation; or (C) does not have the policyholder's principal office in this state; (iii) no more than 25% of the certificate holders or insureds are residents of this state; (iv) on request of the commissioner, the insurer files with the department a copy of the policy and a copy of each form or certificate; and (v)(A) the insurer agrees to pay premium taxes on the Utah portion of the insurer's business, as if the insurer were authorized to do business in this state; and (B) the insurer provides the commissioner with the security the commissioner considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of Admitted Insurers; (i) to the extent provided in Subsection (6): (i) a manufacturer's or seller's warranty; and (ii) a manufacturer's or seller's service contract; (j) except to the extent provided in Subsection (7), a public agency insurance mutual; or (k) except as provided in Chapter 6b, Guaranteed Asset Protection Waiver Act, a guaranteed asset protection waiver. (4) A transaction described in Subsection (3)(e) is subject to taxation under Section 31A-3-301. (5)(a) After a hearing, the commissioner may order an insurer of certain group insurance policies or blanket [~~contracts~~] insurance policies to transfer the Utah portion of the business otherwise exempted under Subsection (3)(h) to an authorized insurer if the contracts have been written by an unauthorized insurer. (b) If the commissioner finds that the conditions required for the exemption of a group or blanket insurer are not satisfied or that adequate protection to residents of this state is not provided, the commissioner may require: (i) the insurer to be authorized to do business in this state; or (ii) that any of the insurer's transactions be subject to this title. (c) Subsection (3)(h) does not apply to a blanket insurance policy offering accident and health insurance. *****	
Lines	**Amendment text**	**Nature of change**
	31A-1-301. Definitions As used in this title, unless otherwise specified: *****	

313	(14) "Blanket insurance policy" or "blanket contract" means a group policy covering a defined class of persons: (a) without individual underwriting or application; and (b) that is determined by definition without designating each person covered. ***** (21) "Captive insurance company" means:	***Technical change:*** Provides consistency for the references related to blanket insurance throughout the insurance code.
340-347	(a) an insurer: (i) owned by [~~another~~] a parent organization; and (ii) whose [~~exclusive~~] purpose is to insure risks of the parent organization and [~~an affiliated company~~] other risks as this chapter authorizes; or (b) in the case of a group or association, an insurer: (i) owned by the insureds; and (ii) whose ~~exclusive~~ purpose is to insure risks of: (A) a member organization; (B) a group member; or (C) an affiliate of: (I) a member organization; or (II) a group member. ***** (79) (a) "Health benefit plan" means, except as provided in Subsection (79)(b), a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care. (b) "Health benefit plan" does not include: (i) coverage only for accident or disability income insurance, or any combination thereof; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit-only insurance; (vii) coverage for on-site medical clinics; (viii) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits; (ix) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:	***Policy change:*** This amendment allows a captive insurance company to be established for a proper purpose in addition to a purpose identified in the statute.

	(A) limited scope dental or vision benefits; (B) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or (C) other similar limited benefits, specified in federal regulations issued pursuant to Pub. L. No. 104-191; (x) the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of benefits and any exclusion of benefits under any health plan, and the benefits are paid with respect to an event without regard to whether benefits are provided under any health plan: (A) coverage only for specified disease or illness; or (B) hospital indemnity or other fixed indemnity insurance; (xi) the following if offered as a separate policy, certificate, or contract of insurance: (A) Medicare supplemental health insurance as defined under the Social Security Act, 42 U.S.C. Sec. 1395ss(g)(1); (B) coverage supplemental to the coverage provided under United States Code, Title 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or (C) similar supplemental coverage provided to coverage under a group health insurance plan;	
738	(xii) short-term[~~, limited duration~~] limited duration health insurance; and (xiii) student health insurance, except as required under 45 C.F.R. Sec. 147.145. *****	***Technical change:*** Create consistency for how the term is used in 31A-1-103, 301 and 31A-22-605.1(5).
1363-1365	[~~(171) "Short-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.~~]	***Technical change:*** This term is no longer used in the Insurance Code.
1366-1369	[~~(172)~~] (171) "Short-term[~~, limited duration~~] limited duration health insurance" means a health benefit product that: (a) after taking into account any renewals or extensions, has a total duration of no more than 36 months; and (b) has an expiration date specified in the contract that is less than 12 months after the original effective date of coverage under the health benefit product.	***Technical change:*** Create consistency for how the term is used in 31A-1-103, 301 and 31A-22-605.1(5).
Lines	**Amendment text**	**Nature of change**
	31A-17-404. Credit allowed a domestic ceding insurer against reserves for reinsurance. *****	
2086-2096	(16) A ceding insurer licensed under Chapter 5, Domestic Stock and Mutual Insurance Corporations, Chapter 7, Nonprofit Health Service Insurance Corporations, Chapter 8, Health	***Policy Change:*** The amendment makes two changes. (1) Under

	Maintenance Organizations and Limited Health Plans, Chapter 9, Insurance Fraternals, or Chapter 14, Foreign Insurers is not allowed credit if the reinsurance is ceded to an assuming domestic or foreign captive insurer, unless the assuming domestic or foreign captive insurer complies with: (a) Chapter 4, Insurers in General; (b) Chapter 16, Insurance Holding Companies; (c) Chapter 16a, Risk Management and Own Risk and Solvency Assessment Act; (d) Chapter 17, Determination of Financial Condition; and (e) Chapter 18, Investments.	current law, a domestic insurer may receive reinsurance credit for ceding to a domestic captive insurer. This amendment allows credit for ceding to a foreign captive insurer. (2) The amendment allows reinsurance credit if the assuming captive insurer complies with financial reporting requirements applicable to non-captive assuming insurers. This requirement enhances the financial stability of the captive reinsurer.
1504-2085	*Note: In legislative bill's version of subsections that precede Section 31A-171-404(16), there a several changes that have been proposed in order to conform the code to drafting norms. Those changes are not substantive and are not summarized here.*	
Lines	**Amendment text**	**Nature of change**
	31A-21-101. Scope of Chapters 21 and 22. (1) Except as provided in Subsections (2) through (6), this chapter and Chapter 22, Contracts in Specific Lines, apply to all insurance policies, applications, and certificates: (a) delivered or issued for delivery in this state; (b) on property ordinarily located in this state; (c) on persons residing in this state when the policy is issued; or (d) on business operations in this state. (2) This chapter and Chapter 22, Contracts in Specific Lines, do not apply to: (a) an exemption provided in Section 31A-1-103; (b) an insurance policy procured under Sections 31A-15-103 and 31A-15-104; (c) an insurance policy on business operations in this state: (i) if: (A) the contract is negotiated primarily outside this state; and (B) the operations in this state are incidental or subordinate to operations outside this state; and (ii) except that insurance required by a Utah statute shall conform to the statutory requirements; or (d) other exemptions provided in this title.	
	(3)(a) Sections 31A-21-102, 31A-21-103, 31A-21-104, Subsections 31A-21-107(1) and (3), and Sections 31A-21-306, 31A-21-308, 31A-21-312, and 31A-21-314 apply to ocean marine and inland marine insurance.	***Codifies practice:*** The amendment makes it clear that travel insurance that includes health

2121-2122 **2123-2127**	(b) Section 31A-21-201 applies to inland marine insurance that is written according to manual rules or rating plans. (c) Inland marine insurance that includes accident and health insurance is subject to Chapter 22, Contracts in Specific Lines. (4) A group insurance policy or a blanket insurance policy is subject to this chapter and Chapter 22, Contracts in Specific Lines, except: (a) a group [~~or blanket~~] insurance policy outside the scope of this title under Subsection 31A-1-103(3)(h); (b) a blanket insurance policy outside the scope of this title under Subsection 31A-1-103(3)(h); and [~~(b)~~] (c) other exemptions provided under Subsection (5). *****	benefits is subject to Title 31A, Chapter 22, Contracts in Specific Lines. In the past, some in industry have disagreed with this position of the Department. ***Technical change:*** Corrects an incorrect reference to blanket insurance policy.
Lines	**Amendment text**	**Nature of change**
	31A-21-201. Filing of forms. (1)(a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may not be used, sold, or offered for sale until the form is filed with the commissioner. (b) A form is considered filed with the commissioner when the commissioner receives: (i) the form; (ii) the applicable filing fee as prescribed under Section 31A-3-103; and (iii) the applicable transmittal forms as required by the commissioner. (2) In filing a form for use in this state the insurer is responsible for assuring that the form is in compliance with this title and rules adopted by the commissioner. (3)(a) The commissioner may prohibit the use of a form at any time upon a finding that: (i) the form: (A) is inequitable; (B) is unfairly discriminatory; (C) is misleading; (D) is deceptive; (E) is obscure; (F) is unfair; (G) encourages misrepresentation; or (H) is not in the public interest; (ii) the form provides benefits or contains another provision that endangers the solidity of the insurer;	

2161	(iii) except for a life or accident and health insurance policy form, the form is an insurance policy or application for an insurance policy, that fails to conspicuously[~~, as defined by rule,~~] provide: (A) the exact name of the insurer; and (B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy; (iv) except an application required by Section 31A-22-635, the form is a life or accident and health insurance policy form that fails to conspicuously[~~, as defined by rule,~~] provide: (A) the exact name of the insurer; (B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy; and (C) for a life insurance policy only, the address of the administrative office of the insurer filing the form; (v) the form violates a statute or a rule adopted by the commissioner; or (vi) the form is otherwise contrary to law. (b)(i) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the <u>day on which the commissioner issues the</u> order, the use of the form be discontinued. (ii) Once use of a form is prohibited, the form may not be used until appropriate changes are filed with and reviewed by the commissioner. (iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to the existing policyholders. (c) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall: (i) be in writing; (ii) constitute an order; and (iii) state the reasons for the prohibition. (4)(a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that a form be subject to the commissioner's approval before [~~its use~~] an insurer uses the form. (b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for a form if the procedures are different from the procedures stated in this section. (c) The type of form that under Subsection (4)(a) the commissioner may require approval of before use includes: (i) a form for a particular class of insurance; (ii) a form for a specific line of insurance;	***Technical change:*** The meaning of the term "conspicuously" can reasonably be determined without the need for a definition in a rule. (*Changes to conform the code to drafting norms that are not substantive.)*
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	(iii) a specific type of form; or (iv) a form for a specific market segment. *****	
Lines	**Amendment text**	**Nature of change**
2224	**31A-21-402. Definitions.** As used in this part: (1)(a) "Direct response solicitation" means any offer by an insurer to persons in this state, either directly or through a third party, to effect life or accident and health insurance coverage which enables the individual to apply or enroll for the insurance on the basis of the offer. (b) Direct response solicitation does not include: (i) solicitations for insurance through an employee benefit plan exempt from state regulation under preemptive federal law[~~, nor does it include~~]; or (ii) solicitations through an [~~the~~] individual's creditor with respect to credit life or credit accident and health insurance. (2) "Mass marketed life or accident and health insurance" means the insurance under any individual, franchise, group, or blanket insurance policy of life or accident and health insurance: (a) that [~~which~~] is offered by means of direct response solicitation through: (i) a sponsoring organization; or [~~through~~] (ii) the mails or other mass communications media; and (b) under which the person insured pays all or substantially all of the cost of [~~his~~] the person's insurance.	***Technical change:*** Corrects reference to defined term 'blanket insurance policy' as defined in 31A-1-301.
Lines	**Amendment text**	**Nature of change**
2233-2235 **2242-2250**	**31A-21-404. Out-of-state insurers.** [~~Any~~] Notwithstanding Subsection 31A-1-103(3)(h), an insurer extending mass marketed life or accident and health insurance under a group insurance policy issued outside of this state to residents of this state or a blanket insurance policy issued outside of this state to residents of this state shall, with respect to the mass marketed life or accident and health insurance policy: (1) comply with: (a) Sections 31A-23a-402, 31A-23a-402.5, and 31A-23a-403; and (b)Chapter 26, Part 3, Claim Practices; and (2) upon the commissioner's request, deliver to the commissioner a copy of: (a) any mass marketed life or accident and health insurance policy[~~, certificates issued under these policies, and~~]; (b) a certificate issued under a mass marketed life or accident and health insurance policy;	***Technical change:*** Corrects references to defined term 'blanket insurance policy' as defined in 31A-1-301.

	(c) an application for a mass marketed life or accident and health insurance policy; (d) an enrollment form for a mass marketed life or accident and health insurance policy; and (e) advertising material used in this state in connection with [~~the~~] a mass marketed life or accident and health insurance policy.	(*Changes to conform the code to drafting norms that are not substantive.)*
Lines	**Amendment text**	**Nature of change**
2253	**31A-22-501. Eligible groups.** A group insurance policy or a blanket insurance policy of life insurance may not be delivered in Utah unless the insured group: (1) falls within at least one of the classifications under Sections 31A-22-501.1 through 31A-22-509; and (2) is formed and maintained in good faith for purposes other than obtaining insurance.	***Technical change:*** Corrects reference to defined term 'blanket insurance policy' as defined in 31A-1-301.
Lines	**Amendment text**	**Nature of change**
2259-2270	**31A-22-522. Required provision for notice of termination.** (1) [~~A policy for~~] If the policy is issued or renewed after July 1, 2001, a group insurance policy for life insurance coverage or a blanket insurance policy for life insurance coverage [~~issued or renewed after July 1, 2001,~~] shall include a provision that obligates the policyholder to notify each employee or group member: (a) in writing; (b) 30 days before the [~~date~~] day on which the coverage [~~is terminated~~] terminates; and (c) (i) that the group insurance policy for life insurance coverage or blanket insurance policy for life insurance coverage is being terminated; and (ii) the rights the employee or group member has to convert coverage upon termination. (2) For a [~~policy for~~] group insurance policy for life insurance coverage or a blanket insurance policy for life insurance coverage described in Subsection (1), an insurer shall: (a) include a statement of a policyholder's obligations under Subsection (1) in the insurer's monthly notice to the policyholder of premium payments due; and (b) provide a sample notice to the policyholder at least once a year.	***Technical change:*** Corrects references to defined term 'blanket insurance policy' as defined in 31A-1-301.
Lines	**Amendment text**	**Nature of change**
	31A-22-600. Scope of Part 6. (1) Except where a provision's application is otherwise specifically limited, this part applies to all: (a) accident and health insurance contracts, including credit accident and health; (b) franchise; (c) group contracts; and (d) [~~a~~] life insurance and annuity [~~policy, but only if~~] policies that directly or through a rider	***Codifies practice:*** Some in

2281- 2285	provide: [~~(i) it includes supplemental benefits and riders including accelerated benefits; and~~] (i) accident and health insurance benefits; or (ii) accelerated benefits where the receipt of benefits is contingent on morbidity requirements. (2) Nothing in this part applies to or affects: (a) workers' compensation insurance; (b) reinsurance; or (c) accident and health insurance when it is part of or supplemental to liability, steam boiler, elevator, automobile, or other insurance covering loss of or damage to property, provided the loss, damage, or expense arises out of a hazard directly related to the other insurance. (3) Except as provided in Subsection (1), this part does not apply to or affect a life insurance or annuity policy including a life insurance policy: (a) with a rider or supplemental benefit that accelerates the death benefit contingent upon a mortality risk specifically for one or more of the qualifying events of: (i) terminal illness; (ii) medical conditions requiring extraordinary medical intervention; or (iii) permanent institutional confinement; and (b) that provides the option of a lump-sum payment for those benefits.	industry file life insurance products that offer an accidental death benefit do not file the death benefit as an accident and health filing. The amendment makes it clear that a life policy that includes an accidental benefit is subject to accident and health requirements.
Lines	**Amendment text**	**Nature of change**
	31A-22-607. Grace period. (1)(a) An individual or franchise accident and health insurance policy shall contain one or more clauses providing for a grace period for premium payment only of: (i) at least 15 days for a weekly or monthly premium policy; and (ii) 30 days for a policy that is not a weekly or monthly premium policy, for each premium after the first premium payment. (b) An insurer may elect to include a grace period that is longer than 15 days for a weekly or monthly policy. (c) An individual or franchise accident and health insurance policy is not in force during a grace period. (d) If an insurer receives payment before the day on which a grace period expires, the individual or franchise accident and health insurance policy continues in force with no gap in coverage. (e) If an insurer does not receive payment before the day on which a grace period expires, the individual or franchise accident and health insurance policy is terminated as of the last date for which the premium is paid in full. (f) A grace period is not required if the policyholder has requested that the individual or franchise	(*Changes to conform the code to drafting norms that are not substantive.)*

	accident and health insurance policy be discontinued.	
2321-2333	(2)(a) A group <u>insurance policy for accident and health insurance</u> or <u>a</u> blanket <u>insurance policy for</u> accident and health insurance ~~policy~~ shall provide for a grace period of at least 30 days, unless the policyholder gives written notice of discontinuance before the [~~date of discontinuance~~] <u>the day on which the policy discontinues</u>, in accordance with the policy terms. (b) A group <u>insurance policy for accident and health insurance</u> or a blanket <u>insurance policy for</u> accident and health insurance [~~policy~~] is in force during a grace period. (c) If an insurer does not receive payment before <u>the day on which</u> a grace period expires, the group <u>insurance policy for accident and health insurance</u> or blanket <u>insurance policy for</u> accident and health insurance [~~policy is terminated~~] <u>terminates</u> as of the last day [~~of~~] <u>on which</u> the grace period <u>Is in effect</u>. (d) A group <u>insurance policy for accident and health insurance</u> or a blanket <u>insurance policy for</u> accident and health insurance [~~policy~~] may provide for payment of a pro rata premium for the period the [~~group or blanket accident and health insurance~~] policy is in effect during a grace period under this Subsection (2).	***Technical change:*** Corrects references to defined term 'blanket insurance policy' as defined in 31A-1-301.
2338	(3) If an insurer has not guaranteed the insured a right to renew an accident and health insurance policy, a grace period beyond the expiration or anniversary date may, if provided in the accident and health insurance policy, be cut off by compliance with the notice provision under Subsection [~~31A-21-303(4)(b)~~]31A-22-618.9.	***Codifies practice:*** Updates reference to a newly proposed section regarding renewability.
2339-2352	<u>(4) (a) An insurer shall send a written renewal notice to the policyholder:</u> <u>(i) between 60 and 14 days before the day on which an accident and health insurance policy renews; or</u> <u>(ii) if the renewal notice includes a change in premium, at least 45 days before the day on which an accident and health insurance policy renews.</u> <u>(b) The renewal notice described in Subsection (4)(a) shall clearly state:</u> <u>(i) the renewal premium amount;</u> <u>(ii) how the policyholder may pay the renewal premium, including the day on which the renewal premium is due; and</u> <u>(iii) that failure of the policyholder to pay the renewal premium extinguishes the policyholder's right to renew.</u> <u>(5) The extinguishment of a policyholder's right to renew for nonpayment of premium is effective no sooner than 10 days after the day on which the policyholder receives written notice that the policyholder has failed to pay the premium when due.</u>	***Technical change:*** This amendment adds language that has been removed from Section 31A-21-303(4)(b), line 2338.
Lines	**Amendment text**	**Nature of change**
	31A-22-608. Reinstatement of individual or franchise accident and health insurance policies.	

2357	(1) Every individual or franchise accident and health insurance policy shall contain a provision which reads substantially as follows: "REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement." (2) The last sentence of the provision described [~~set forth~~] in Subsection (1) may be omitted from any policy that the insured has the right to continue in force subject to [~~its~~] the policy's terms by the timely payment of premiums until at least age 50, or in the case of a policy issued after age 44, for at least five years from [~~its date of issue~~] the day on which the insurer issues the policy..	***Codifies practice:*** The amendment clarifies that a policy's reinstatement provision must be similar to, but need not be identical to, the example language in the statute. Clarify language must be similar instead as verbatim. (*Changes to conform the code to drafting norms that are not substantive.)*
Line	**Amendment text**	**Nature of change**
2381-2404	**31A-22-612. Conversion privileges for insured former spouse.** (1) An accident and health insurance policy, [which] that in addition to covering the insured also provides coverage to the spouse of the insured, may not contain a provision for termination of coverage of a spouse covered under the policy, except by entry of a valid decree of divorce, legal separation, or annulment between the parties. (2) (a) Every policy [~~which~~] that contains [~~this~~] the type of provision described in Subsection (1) shall: (i) provide that upon the entry of the divorce decree the spouse is entitled to have issued an individual policy of accident and health insurance without evidence of insurability, upon application to the company and payment of the appropriate premium[~~. The policy shall~~]; and	(*Changes to conform the code to drafting norms that are not substantive.)*

2408-2409	(ii) provide the coverage being issued [~~which~~] that is most nearly similar to the terminated coverage. [~~Probationary or waiting periods in the policy are~~] ~~(b) A probationary or waiting period in a policy described in Subsection (1)~~ is considered satisfied to the extent the coverage was in force under the prior policy. (3) (a) When [~~the~~] an insurer receives actual notice that the coverage of a spouse is to be terminated because of a divorce, legal separation, or annulment, the insurer shall promptly provide the spouse written notification of the right to obtain individual coverage as provided in Subsection (2), the premium amounts required, and the manner, place, and time in which premiums may be paid. (b) The premium is determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of the persons to be covered and to the type and amount of coverage provided. (c) If [~~the~~] a spouse applies and tenders the first monthly premium to the insurer within 30 days after [~~receiving~~] the day on which the spouse receives the notice provided by this Subsection (3), the spouse shall receive individual coverage that commences immediately upon termination of coverage under the insured's policy. (4) This section does not apply to a blanket insurance policy providing accident and health insurance [~~policies offered on a group blanket basis~~] or a health benefit plan.	***Technical change:*** Corrects references to defined term 'blanket insurance policy' as defined in 31A-1-301.
Lines	**Amendment text**	**Nature of change**
	31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit plans. (1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force: (a) with respect to all eligible employees and dependents; and (b) at the option of the plan sponsor. (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed: (a) for noncompliance with the insurer's employer contribution requirements; (b) if there is no longer any enrollee under the group health plan who lives, resides, or works in: (i) the service area of the insurer; or (ii) the area for which the insurer is authorized to do business; (c) for coverage made available in the small or large employer market only through an association, if: (i) the employer's membership in the association ceases; and (ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual; or (d) for noncompliance with the insurer's minimum employee participation requirements, except	

	as provided in Subsection (3). (3) If a small employer no longer employs at least one eligible employee, a carrier may not discontinue or not renew the health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows at the beginning of the plan year that the employer no longer has at least one eligible employee. (4)(a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the small group market. (b) A large employer that, after purchasing a health benefit plan in the large group market, employs on average fewer than 51 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the large group market. (5) A health benefit plan for a plan sponsor may be discontinued if: (a) a condition described in Subsection (2) exists; (b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract; (c) the plan sponsor: (i) performs an act or practice that constitutes fraud; or (ii) makes an intentional misrepresentation of material fact under the terms of the coverage; (d) the insurer:	
2452	(i) elects to discontinue offering a particular health benefit plan [~~product~~] delivered or issued for delivery in this state; [~~and~~] (ii)[~~(A)~~] provides notice of the discontinuation in writing to each plan sponsor[~~, employee, or dependent of a plan sponsor or an employee~~] and certificate holder, at least 90 days before the [~~date~~] day on which the coverage [~~will be discontinued~~] discontinues; [~~(B)~~] (iii) provides notice of the discontinuation in writing to the commissioner, and at least three working days before the [~~date~~] day on which the notice is sent to [~~the~~] each affected plan [~~sponsors, employees, and dependents of the plan sponsors or employees~~] sponsor or and certificate holder; [~~(C)~~](iv) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other health benefit plans currently being offered by the insurer in the market or, in the case of a large employer, any other health benefit plans currently being offered in that market; and [~~(D)~~] (v) in exercising the option to discontinue that health benefit plan and in offering the option of coverage in this section, acts uniformly without regard to the claims experience of a plan sponsor, any health status-related factor relating to any covered participant or beneficiary, or any health status-related factor relating to any new participant or beneficiary who may become	***Technical change:*** The amendment clarifies who receives a notice of discontinuance of a group health benefit plan according to plan level, rather than the product level. (*Changes to conform the code to drafting norms that are not substantive.)*

eligible for the coverage; or
(e) the insurer:
(i) elects to discontinue all of the insurer's health benefit plans in:
(A) the small employer market;
(B) the large employer market; or
(C) both the small employer and large employer markets; and
(ii)[~~(A)~~] provides notice of the discontinuation in writing to each plan sponsor[~~, employee, or dependent of a plan sponsor or an employee~~] and certificate holder at least 180 days before the [~~date~~] day on which the coverage [~~will be discontinued~~]discontinues;
[~~(B)~~](iii) provides notice of the discontinuation in writing to the commissioner in each state in which an affected insured individual is known to reside and, at least 30 working days before the [~~date~~] day on which the notice is sent to each [~~the~~] affected plan [~~sponsors, employees, and the dependents of the plan sponsors or employees~~] and affected insured individual;
[~~(C)~~](iv) discontinues and nonrenews all plans issued or delivered for issuance in the market described in Subsection (5)(e)(i); and
[~~(D)~~] (v) provides a plan of orderly withdrawal as required by Section 31A-4-115.
(6) (a) Except as provided in Subsection (6)(d), an eligible [~~employee~~] may be discontinued if after issuance of coverage the eligible employee:
(i) engages in an act or practice in connection with the coverage that constitutes fraud; or (ii) makes an intentional misrepresentation of material fact in connection with the coverage.
(b) An eligible employee [~~that~~] whose coverage is discontinued under Subsection (6)(a) may reenroll:
(i) 12 months after the [~~date of discontinuance~~] day on which the employee's coverage discontinues; and
(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.
(c) At the time the eligible employee's coverage [~~is discontinued~~] discontinues under Subsection (6)(a), the insurer shall notify the eligible employee of the right to reenroll [~~when coverage is discontinued~~] as described in Subsection (6)(b).
(d) An eligible [~~employee~~] employee's coverage may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.
(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:
(a) with respect to coverage provided to an employer member of the association; and
(b) if the health benefit plan is made available by an insurer in the employer market only through:
(i) an association;

	(ii) a trust; or (iii) a discretionary group. (8) An insurer may modify a health benefit plan for a plan sponsor only: (a) at the time of coverage renewal; and (b) if the modification is effective uniformly among all plans with that product.	
Lines	**Amendment text**	**Nature of change**
	31A-22-618.7. Discontinuance and nonrenewal for individual health benefit plans. (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force: (i) with respect to all enrollees or dependents; and (ii) at the option of the enrollee. (b) Subsection (1)(a) applies regardless of: (i) whether the contract is issued through: (A) a trust; (B) an association; (C) a discretionary group; or (D) other similar grouping; or (ii) the situs of delivery of the policy or contract. (2) An individual health benefit plan may be discontinued or nonrenewed: (a) if: (i) there is no longer an enrollee under the individual health benefit plan who lives, resides, or works in: (A) the service area of the insurer; or (B) the area for which the insurer is authorized to do business; and (ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered enrollee; or (b) for coverage made available through an association, if: (i) the enrollee's membership in the association ceases; and (ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered enrollee. (3) An individual health benefit plan may be discontinued if: (a) a condition described in Subsection (2) exists; (b) the enrollee fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements; (c) the enrollee:	

2552-2571	(i) performs an act or practice in connection with the coverage that constitutes fraud; or (ii) makes an intentional misrepresentation of material fact under the terms of the coverage; (d) the insurer: (i) elects to discontinue offering a particular health benefit plan product delivered or issued for delivery in this state; and (ii) (A) provides notice of the discontinuation in writing to each enrollee provided coverage at least 90 days before the [~~date~~] day on which the coverage [~~will be discontinued~~] discontinues; (B) provides notice of the discontinuation in writing to the commissioner and, at least three working days before the [~~date~~] day on which the notice is sent, to [~~the affected enrollees~~] each affected enrollee; (C) offers to each covered enrollee on a guaranteed issue basis the option to purchase all other individual health benefit plans currently being offered by the insurer for individuals in that market; and (D) acts uniformly without regard to any health status-related factor of covered enrollees or dependents of covered enrollees who may become eligible for coverage; or (e) the insurer: (i) elects to discontinue all of the insurer's health benefit plans in the individual market; and (ii) (A) provides notice of the discontinuation in writing to each enrollee provided coverage at least 180 days before the [~~date~~] day on which the coverage [~~will be discontinued~~]discontinues; (B) provides notice of the discontinuation in writing to the commissioner in each state in which an affected enrollee is known to reside and, at least 30 working days before the [~~date~~] day on which the insurer sends the notice [~~is sent, to the affected enrollees~~], to each affected enrollee; (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for issuance in the individual market; and (D) acts uniformly without regard to any health status-related factor of covered enrollees or dependents of covered enrollees who may become eligible for coverage. (4) An insurer may modify an individual health benefit plan only: (a) at the time of coverage renewal; and (b) if the modification is effective uniformly among all health benefit plans.	(*Changes to conform the code to drafting norms that are not substantive.)*
Lines	**Amendment text**	**Nature of change**
	31A-22-618.8. Discontinuance and nonrenewal limitations for health benefit plans. (1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health benefit plan under Subsections 31A-22-618.6(5)(e) and 31A-22-618.7(3)(e) is prohibited from writing new business: (a) in the market in this state for which the insurer discontinues or does not renew; and	

2586-2587	(b) for a period of five years beginning on the [~~date of discontinuation of~~] day on which the last coverage [~~that~~] is discontinued. (2) If an insurer is doing business in one established geographic service area of the state, Sections 31A-22-618.6 and 31A-22-618.7 apply only to the insurer's operations in that 2571 service area. (3) The commissioner may, by rule or order, define the scope of service area.	(*Changes to conform the code to drafting norms that are not substantive.)*
Lines	**Amendment text**	**Nature of change**
2593-2637	**31A-22-618.9. Discontinuance, nonrenewal, and changes to accident and health insurance coverage.** (1) As used in this section: (a) "Conditionally renewable policy" means an accident and health insurance policy that an insurer may decline to renew because of class, geographic area, or for a stated reason other than deterioration of health. (b) "Guaranteed renewable policy" means an accident and health insurance policy that an insurer: (i) may not refuse to renew for any reason; and (ii) may revise the rates of on a class basis. (c) "Non-cancelable policy" means an accident and health insurance policy that an insurer may not: (i) refuse to renew for any reason; or (ii) revise the rates of for any reason. (d) "Optionally renewable policy" means an accident and health insurance policy that the insurer has the option of renewing. (2) Except as provided in Sections 31A-22-618.6 and 31A-22-618.7, an insurer may decline to renew a conditionally renewable policy, a guaranteed renewable policy, or an optionally renewable policy on the day on which: (a) the agreed upon policy term expires; or (b) the policy renews, if the insurer provides notice of nonrenewal at least 90 days before the day on which the nonrenewal takes effect. (3) Notwithstanding Subsection (2), an insurer may cancel a conditionally renewable policy, a guaranteed renewable policy, a non-cancelable policy, or an optionally renewable policy for: (a) nonpayment of a premium when due, including timeliness requirements; (b) intentional material misrepresentation of a material fact in connection with the coverage; (c) performance of an act or practice that constitutes fraud in connection with the coverage; or (d) noncompliance with employer eligibility provisions.	***Codifies practice:*** 1. Codifies language in Rules R590-85, 126 and 277. 2. Clarifies that, for products other a health benefit plan, coverage cannot be terminated at the option of the insurer outside of renewal and unless specific requirements are met.

	(4) Except for a modification required by law, an insurer may only modify a conditionally renewable policy, a guaranteed renewable policy, or an optionally renewable policy: (a) at the time of coverage renewal; and (b) if the modification is effective uniformly among similar policies. (5) (a) Subject to Subsection (5)(b), an insurer shall obtain the policyholder's signed acceptance for an endorsement: (i) that reduces or eliminates benefits or coverage of a policy; and (ii) added to a policy: (A) after the day on which the insurer issues the policy; or (B) at reinstatement or renewal of the policy. (b) Subsection (5)(a) does not apply to an endorsement by which the insurer: (i) effectuates a request the policyholder made in writing; or (ii) exercises a specifically reserved right under the policy.	
Lines	**Amendment text**	**Nature of change**
2641-2654	**31A-22-627. Coverage of emergency medical services.** (1) A health insurance policy or managed care organization contract: (a) shall provide[~~, at a minimum,~~] coverage of emergency services [~~as required in 29 C.F.R. Sec. 2590.715-2719A~~]; and (b) may not: (i) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized; [~~or~~] (ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured[~~.~~]; or (iii) impose any cost-sharing requirement for out-of-network that exceed the cost-sharing requirement imposed for in-network. (2) (a) A health insurance policy or managed care organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's condition has been stabilized. (b) If [~~such~~] authorization described in Subsection (2)(a) is required, an insurer who does not accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected the request for authorization. (3) For purposes of this section: (a) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who	***Technical Change:*** The department receives repeated questions from health insurer regarding the interplay with federal law. The amendment removes the incorporation of federal law and incorporates the same requirements on lines 2649-2650.

	possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention through a hospital emergency department to result in: (i) placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. (b) "Hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis. (c) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3). (4) Nothing in this section may be construed as: (a) altering the level or type of benefits that are provided under the terms of a contract or policy; or (b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract. (5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has violated this section, the commissioner may: (a) work with the insurer to improve the insurer's compliance with this section; or (b) impose the following fines: (i) not more than $5,000; or (ii) twice the amount of any profit gained from violations of this section.	
Lines	**Amendment text**	**Nature of change**
	31A-22-701. Groups eligible for group or blanket insurance. (1) As used in this section, "association group" means a lawfully formed association of individuals or business entities that: (a) purchases insurance on a group basis on behalf of members; and (b) is formed and maintained in good faith for purposes other than obtaining insurance. (2) A group [~~accident and health~~] insurance policy <u>offering accident and health</u> may be issued to: (a) a group: (i) to which a group life insurance policy may be issued under Section 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-506, or 31A-22-507; and (ii) that is formed and maintained in good faith for a purpose other than obtaining insurance; (b) an association group authorized by the commissioner that: (i) has been actively in existence for at least five years; (ii) has a constitution and bylaws; (iii) has a shared [~~or~~] <u>substantially</u> common purpose that [~~is not primarily a business or customer~~	(*Changes to conform the code to drafting norms that are not substantive.)*

2697-2701	~~relationship~~]: (A) is the same profession, trade, occupation, or similar; or (B) is unrelated to the provision of benefits, by some common economic, representation of interest, or genuine organizational relationship; (iv) is formed and maintained in good faith for purposes other than obtaining insurance; (v) does not condition membership in the association group on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee; (vi) makes accident and health insurance coverage offered through the association group available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member; (vii) does not make accident and health insurance coverage offered through the association group available other than in connection with a member of the association group; and (viii) is actuarially sound; [~~or~~] (c) a group specifically authorized by the commissioner, upon a finding that: (i) authorization is not contrary to the public interest; (ii) the group is actuarially sound; (iii) formation of the proposed group may result in economies of scale in acquisition, administrative, marketing, and brokerage costs; (iv) the insurance policy, insurance certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to insurance policies that are otherwise available to similar groups; (v) the group would not present hazards of adverse selection; (vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided; and (vii) the group is formed and maintained in good faith for a purpose other than obtaining insurance[~~.~~]; or	***Codifies Practice:*** The amendment clarifies what constitutes an "association group" that is allowed to purchase insurance on behalf of group members. The amendment also makes the statute consistent with Sections 31A-30-104(4)(a)(i)(A) and 31A-22-505(2)(d).
2727-2735	(d) a postsecondary educational institution covering students, upon a finding that: (i) the policy provides standards for financial soundness of such plan; (ii) the policy protects the students covered; (iii) the policy provides for the establishment of financially viable alternative to traditional health care plans; (iv) authorization is not contrary to the public interest; (v) the group would not present hazards of adverse selection; and (vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided.	***Policy change:*** Establishes that a higher educational institution may be an eligible group for the purpose of providing student coverage.

2736-2771	(3) A blanket <u>insurance policy offering</u> accident and health insurance ~~policy~~: (a) covers a defined class of persons; (b) may not be offered or underwritten on an individual basis; (c) shall cover only a group that is: (i) actuarially sound; and (ii) formed and maintained in good faith for a purpose other than obtaining insurance; and (d) may be issued only to: (i) a common carrier or an operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to the person's travel status; (ii) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder; (iii) an institution of learning, including a school district, a school jurisdictional unit, or the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering students, teachers, or employees; (iv) a religious, charitable, recreational, educational, or civic organization, or branch of one of those organizations, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder; (v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering members, campers, employees, officials, or supervisors; (vi) a volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder; (vii) a newspaper or other publisher, as policyholder, covering its carriers; (viii) a labor union, as a policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; (ix) an association that has a constitution and bylaws covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; or (x) any other class of risks that, in the judgment of the commissioner, may be properly eligible for <u>a</u> blanket <u>insurance policy offering</u> accident and health insurance. (4) The judgment of the commissioner may be exercised on the basis of: (a) individual risks;	***Technical change:*** Corrects references to defined term 'blanket insurance policy' as defined in 31A-1-301.

	(b) a class of risks; or (c) both Subsections (4)(a) and (b).	
Lines	**Amendment text**	**Nature of change**
2777-2787	**31A-22-716. Required provision for notice of termination.** (1) [~~A policy for~~] If a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health [~~coverage~~] insurance is issued or renewed after July 1, 1990, the policy shall include a provision that obligates the policyholder: (a) to give [~~30 days prior~~] written notice of termination to each employee or group member 30 days before the day on which the policy terminates; and (b) to notify each employee or group member of the employee's or group member's rights to continue coverage upon termination. (2) (a) An insurer's monthly notice to the policyholder of premium payments due shall include a statement of the policyholder's obligations as set forth in Subsection (1). (b) Insurers shall provide a sample notice to the policyholder at least once a year.	***Technical change:*** Corrects references to defined term 'blanket insurance policy' as defined in 31A-1-301. (*Changes to conform the code to drafting norms that are not substantive.)*
Lines	**Amendment text**	**Nature of change**
2789-2802	**31A-22-717. Provisions pertaining to service members and their families affected by mobilization into the armed forces.** For [~~any~~] a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health [~~coverage~~]insurance, an insurer: (1) may not refuse to reinstate an insured or [~~his~~] the insured's family whose coverage lapsed due to the insured's mobilization into the United States armed forces provided application is made within 180 days [~~of release~~] after the day on which the insured is released from active duty; (2) shall reinstate an insured in full upon payment of the first premium without the requirement of a waiting period or exclusion for preexisting conditions or any other underwriting requirements that were covered previously; and (3) may not increase the insured's premium in excess of what [~~it~~] the premium would have been increased to in the normal course of time had the insured not been mobilized into the United States armed forces.	***Technical change:*** Corrects references to defined term 'blanket insurance policy' as defined in 31A-1-301. (*Changes to conform the code to drafting norms that are not substantive.)*
Lines	**Amendment text**	**Nature of change**
	31A-22-1404. Rulemaking authority. The commissioner may adopt rules that may permit or include: (1) the increase of benefits over time;	

2825	(2) standards for full and fair disclosure of the manner, content, and required disclosures for the sale of long-term care insurance policies; (3) terms of renewability; (4) initial and subsequent conditions of eligibility; (5) nonduplication of coverage provisions; (6) coverage of dependents; (7) termination of coverage; (8) continuation or conversion; (9) probationary periods; (10) limitations, exceptions, and reductions of coverage; (11) preexisting conditions; (12) elimination and waiting periods; (13) requirements for replacement; (14) recurrent conditions; (15) definition of terms; (16) loss ratio requirements; (17) post claim underwriting; (18) waiver of premium; (19) <u>independent review of benefit determinations;</u> <u>(20)</u> inflation protection benefits; and [~~(20)~~]<u>(21)</u> premium rate filing and review.	***Codifies practice:*** Currently, long-term care insurance policies are required to include an independent review of benefit determinations. This amendment incorporates the language in the NAIC model from which this code section is based.
Lines	**Amendment text**	**Nature of change**
2840-2841	**31A-23a-113. License lapse, and voluntary surrender.** (1)(a) A license issued under this chapter, including a line of authority, shall lapse if the licensee fails to: (i) pay when due a fee under Section 31A-3-103; (ii) complete continuing education requirements under Section 31A-23a-202 before submitting the license renewal application; (iii) submit a completed renewal application as required by Section 31A-23a-104; (iv) submit additional documentation required to complete the licensing process as related to a specific license type or line of authority; or (v) maintain an active license in a licensee's home state if the licensee is a nonresident licensee. <u>(b) A license that lapses shall expire effective at midnight on the day on which the license expires.</u> [~~(b)~~]<u>(c)</u>(i) A licensee whose license lapses may request reinstatement of the license and line of authority no more than one year after the day on which the license lapses.	***Codifies practice:*** This change is made to be create consistency

	(ii) A licensee whose license lapses due to the following may request an action described in Subsection (1)[~~(b)~~](c)(iii): (A) military service; (B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or (C) some other extenuating circumstances, [such as] including long-term medical disability. (iii) A licensee described in Subsection (1) [~~(b)~~](c)(ii) may request: (A) reinstatement of the license and line of authority no later than one year after the day on which the license lapses; and (B) waiver of any of the following imposed for failure to comply with renewal procedures: (I) an examination requirement; (II) reinstatement fees set under Section 31A-3-103; (III) continuing education requirements; or (IV) other sanction imposed for failure to comply with renewal procedures. (2) If a license or line of authority issued under this chapter is voluntarily surrendered, the license or line of authority may be reinstated: (a) during the license period in which the license or line of authority is voluntarily surrendered; and (b) no later than one year after the day on which the license or line of authority is voluntarily surrendered.	among the states in their treatment of lapsed licenses.
Lines	**Amendment text**	**Nature of change**
	31A-23a-201. Exceptions to producer licensing. (1) The commissioner may not require a license as an insurance producer of: (a) an officer, director, or employee of an insurer or of an insurance producer if: (i) the officer, director, or employee does not receive any commission on a policy written or sold to insure risks residing, located, or to be performed in this state; and (ii)(A) the officer's, director's, or employee's activities are: (I) executive, administrative, managerial, clerical, or a combination of these activities; and (II) only indirectly related to the sale, solicitation, or negotiation of insurance; (B) the officer's, director's, or employee's function relates to: (I) underwriting; (II) loss control; (III) inspection; or (IV) the processing, adjusting, investigating or settling of a claim on a contract of insurance; or	

2894	(C)(I) the officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting an insurance producer; (II) the officer's, director's, or employee's activities are limited to providing technical advice and assistance to a licensed insurance producer; and (III) the officer's, director's, or employee's activities do not include the sale, solicitation, or negotiation of insurance; (b) a person who: (i) is paid no commission for the services described in Subsection (1)(b)(ii); and (ii) secures and furnishes information for the purpose of: (A) group life insurance; (B) group property and casualty insurance; (C) group annuities; (D) group insurance policy or blanket insurance policy for accident and health insurance; (E) enrolling individuals under plans; (F) issuing certificates under plans; or (G) otherwise assisting in administering plans; (c) a person who: (i) is paid no commission for the services described in Subsection (1)(c)(ii); and (ii) performs administrative services related to mass marketed property and casualty insurance; (d)(i) any of the following if the conditions of Subsection (1)(d)(ii) are met: (A) an employer or association; or (B) an officer, director, employee, or trustee of an employee trust plan; (ii) a person listed in Subsection (1)(d)(i): (A) to the extent that the employer, officer, employee, director, or trustee is engaged in the administration or operation of a program of employee benefits for: (I) the employer's or association's own employees; or (II) the employees of a subsidiary or affiliate of an employer or association; (B) the program involves the use of insurance issued by an insurer; and (C) the employer, association, officer, director, employee, or trustee is not in any manner compensated, directly or indirectly, by the company issuing the contract; (e) an employee of an insurer or organization employed by an insurer who: (i) is engaging in: (A) the inspection, rating, or classification of risks; or (B) the supervision of the training of insurance producers; and (ii) is not individually engaged in the sale, solicitation, or negotiation of insurance;	***Technical change:*** Corrects references to defined term 'blanket insurance policy' as defined in 31A-1-301.

	(f) a person whose activities in this state are limited to advertising: (i) without the intent to solicit insurance in this state; (ii) through communications in mass media including: (A) a printed publication; or (B) a form of electronic mass media; (iii) that is distributed to residents outside of the state; and (iv) if the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state; (g) a person who: (i) is not a resident of this state; (ii) sells, solicits, or negotiates a contract of insurance: (A) for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract; and (B) insures risks located in a state in which the person is licensed as provided in Subsection (1)(g)(iii); and (iii) is licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business; or (h) if the employee does not sell, solicit, or receive a commission for a contract of insurance, a salaried full-time employee who counsels or advises the employee's employer relating to the insurance interests of: (i) the employer; or (ii) a subsidiary or business affiliate of the employer. *****	
Lines	**Amendment text**	**Nature of change**
2966-2978	**31A-23a-406. Title insurance producer's business.** (1) An individual title insurance producer or agency title insurance producer may do escrow involving real property transactions if all of the following exist: ***** (d) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow~~[.~~ ~~(i) ~~]is deposited: [~~(A)~~](i) in a federally insured [~~financial~~] depository institution as defined in Section 7-1-103, that: (A) has an office in this state, if the licensee depositing the money is a resident licensee; and (B) is authorized by its primary regulator to engage in the trust business, as defined by Section 7-5-1, in this state; and	***Technical change:*** The amendments require deposits in a "depository institution" rather than the broader "financial institution." They also require that the institution have an office in this state. These changes

	[~~(B)~~] (ii) in a trust account that is separate from all other trust account money that is not related to real estate transactions; [~~(ii)~~] (e) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow is the property of the one or more persons entitled to the money under the provisions of the escrow; and [~~(iii)~~] (f) money deposited with the individual title insurance producer or agency title insurance producer in connection with an escrow is segregated escrow by escrow in the records of the individual title insurance producer or agency title insurance producer; [~~(c)~~] (g) earnings on money held in escrow may be paid out of the escrow account to any person in accordance with the conditions of the escrow; [~~(f)~~] (h) the escrow does not require the individual title insurance producer or agency title insurance producer to hold: (i) construction money; or (ii) money held for exchange under Section 1031, Internal Revenue Code; and [~~(g)~~] (i) the individual title insurance producer or agency title insurance producer shall maintain a physical office in Utah staffed by a person with an escrow subline of authority who processes the escrow. *****	harmonize the depository requirements for Department licensees under Sections 31A-23a-406 and 31A-23a-409.
Lines	**Amendment text**	**Nature of change**
3087-3090	**31A-23a-409. Trust obligation for money collected.** ***** (2) Money required to be deposited under Subsection (1) shall be deposited: (a) in a federally insured trust account in a depository institution, as defined in Section 7-1-103, which: (i) has an office in this state, if the licensee depositing the money is a resident licensee; (ii) has federal deposit insurance; and (iii) is authorized by its primary regulator to engage in the trust business, as defined by Section 7-5-1, in this state; or (b) in some other account, [~~approved by~~] that: (i) the commissioner approves by rule or order[~~, providing~~]; and (ii) provides safety comparable to [~~federally insured trust accounts~~] an account described in Subsection (2)(a). *****	***Technical change:*** Removes a loophole in the statute that currently allows deposits in an institution that does not have an office in Utah.
Lines	**Amendment text**	**Nature of change**
	31A-26-102. Definitions. As used in this chapter, unless expressly provided otherwise:	

3110-3126	(1) "Company adjuster" means a person employed by an insurer [~~, or an entity under common control or ownership with the insurer,~~] who negotiates or settles claims on behalf of the [~~employer~~] <u>insurer or an affiliated insurer</u>. (2) "Designated home state" means the state or territory of the United States or the District of Columbia: (a) in which an insurance adjuster does not maintain the adjuster's principal: (i) place of residence; or (ii) place of business; (b) if the resident state, territory, or District of Columbia of the adjuster does not license adjusters for the line of authority sought, the adjuster has qualified for the license as if the person were a resident in the state, territory, or District of Columbia described in Subsection (2)(a), including an applicable: (i) examination requirement; (ii) fingerprint background check requirement; and (iii) continuing education requirement; and (c) the adjuster has designated [~~the state, territory, or District of Columbia~~] as the <u>insurance adjuster's</u> home state. (3) "Home state" means: (a) a state or territory of the United States or the District of Columbia in which an insurance adjuster: (i) maintains the adjuster's principal: (A) place of residence; or (B) place of business; and (ii) is licensed to act as a resident adjuster; or (b) if the resident state, territory, or the District of Columbia described in Subsection (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District of Columbia: (i) in which the adjuster is licensed; (ii) in which the adjuster is in good standing; and (iii) that the adjuster has designated as the adjuster's designated home state. (4) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of one or more insurers. (5) "Insurance adjusting" or "adjusting" means directing or conducting the investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an insurer, policyholder, or a claimant under an insurance policy.	***Clarifies practice:*** The amendment makes it clear that a company adjuster to which this Section applies must be employed by an insurer or its affiliated insurer rather than an affiliated non-insurer entity.

	(6) "Organization" means a person other than a natural person, and includes a sole proprietorship by which a natural person does business under an assumed name. (7) "Portable electronics insurance" is as defined in Section 31A-22-1802. (8) "Public adjuster" means a person required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants under insurance policies.	
Lines	**Amendment text**	**Nature of change**
	31A-28-103. Coverage and limitations. ***** (7) This part does not provide coverage for: (a) a portion of a policy or contract: (i) not guaranteed by the member insurer; or (ii) under which the risk is borne by the policy or contract owner; (b) a policy or contract of reinsurance, unless: (i) an assumption certificate is issued before the coverage date; (ii) the assumption certificate required by Subsection (7)(b)(i) is in effect pursuant to the reinsurance policy or contract; and (iii) the reinsurance contract is approved by the appropriate regulatory authorities; (c) except as provided in Subsection (11)(e), a portion of a policy or contract to the extent that the rate of interest on which the policy or contract is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value exceeds: (i) a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged: (A) over the period of four years before the coverage date with respect to the policy or contract; or (B) for the corresponding lesser period if the policy or contract was issued less than four years before the association became obligated; or (ii) a rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available as determined on or after the earlier of: (A) the day on which the member insurer becomes an impaired insurer; or (B) the day on which the member insurer becomes an insolvent insurer; (d) a portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, accident and health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including benefits	

	payable by an employer, association, or other person under: (i) a multiple employer welfare arrangement, as that term is defined in 29 U.S.C. Sec. 1002; (ii) a minimum premium group insurance plan; (iii) a stop-loss group insurance plan; or (iv) an administrative services only contract; (e) a portion of a policy or contract to the extent that it provides: (i) a dividend; (ii) an experience rating credit; (iii) voting rights; or (iv) payment of a fee or allowance to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract; (f) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payment with respect to the benefit plan; (g) a portion of an unallocated annuity contract that is not issued to or in connection with: (i) a specific benefit plan of: (A) employees; (B) a union; or (C) an association of natural persons; or (ii) a government lottery; (h) a portion of a policy or contract to the extent that the assessment required by Section 31A-28-109 that applies to the policy or contract is preempted by federal or state law; (i) an obligation that does not arise under the express written terms of the policy or contract issued by a member insurer to the enrollee, certificate holder, contract owner, or policy owner, including: (i) a claim based on marketing materials; (ii) a claim based on a side letter, rider, or other document that is issued by the member insurer without meeting applicable policy or contract form filing or approval requirements; (iii) a misrepresentation regarding a policy or contract benefit; (iv) an extra-contractual claim; (v) a claim for penalties; or (vi) a claim for consequential or incidental damages; (j) a contract that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a	

	portfolio of assets that is owned by a person that is: (i) (A) the benefit plan; or (B) the benefit plan's trustee; and (ii) not an affiliate of the member insurer; (k) a portion of a policy or contract to the extent it provides for interest or other changes in value: (i) to be determined by the use of an index or other external reference stated in the policy or contract; and (ii) as of the date the member insurer becomes an impaired or insolvent insurer, whichever occurs earlier: (A) that have not been credited to the policy or contract; or (B) as to which the policy or contract owner's rights are subject to forfeiture; (l) a policy or contract providing hospital, medical, prescription drug, or other health care benefit pursuant to: (i) Part C or D of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.; [~~or~~] (ii) Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq.; or	
3314	<u>(iii) Title XXI of the Social Security Act, 42 U.S.C. Sec. 1397aa et seq.; or</u> (m) a structured settlement annuity benefit to which a payee or beneficiary has transferred the payee or beneficiary's rights in a structured settlement factoring transaction, regardless of whether the transaction occurred before or after 26 U.S.C. Sec. 5891(c)(3)(A) became effective. ***** (11) (a) The limitations set forth in Subsections (8) and (9) are limitations on the benefits for which the association is obligated before taking into account: (i) the association's subrogation and assignment rights; or (ii) the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. (b) The costs of the association's obligations under this part may be met by the use of assets: (i) attributable to covered policies, as described in Subsection 31A-28-114(3)(c); or (ii) reimbursed to the association pursuant to the association's subrogation and assignment rights. (c) Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term care rider relates. (d) In performing [~~its~~] <u>the association's</u> obligations to provide coverage under Section 31A-28-108, the association may not be required to guarantee, assume, reinsure, reissue, perform, or	***Codifies practice:*** Clarifies that there is (1) no guaranty association coverage for the benefits provided by health insurers for the CHIP program under the supervision of the Utah Health Department, and (2) CHIP considerations are not considered premiums in determining the assessment base for such insurers for guaranty association assessment purposes.

	cause to be guaranteed, assumed, reinsured, reissued, or performed a contractual obligation of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic values or economic benefits of the covered policy or contract. (e) The exclusion from coverage described in Subsection (7)(c) does not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other accident and health insurance benefit.	
Line	**Amendment text**	**Nature of change**
3408-3427	**31A-35-404. Minimum financial requirements for bail bond agency license.** (1) (a) A bail bond agency that pledges the assets of a letter of credit from a Utah depository institution in connection with a judicial proceeding shall maintain an irrevocable letter of credit with a minimum face value of $300,000 assigned to the state from a Utah depository institution. (b) Notwithstanding Subsection (1)(a), a bail bond agency described in Subsection (1)(a) that is licensed under this chapter [~~as of~~] on or before December 31, 1999, shall maintain an irrevocable letter of credit with a minimum face value of $250,000 assigned to the state from a Utah depository institution. (2) (a) A bail bond agency that pledges personal or real property, or both, as security for a bail bond in connection with a judicial proceeding shall maintain[~~:~~ ~~(i) (A)~~] a verified financial statement for the current year: (I) reviewed by a certified public accountant; and (II) showing a minimum net worth of [~~at least~~]: (A) $300,000, at least $100,000 of which is in liquid assets; or (B) if the bail bond agency is licensed under this chapter on or before December 31, 1999, $250,000, at least $50,000 of which is in liquid assets. [~~notwithstanding Subsection (2)(a)(i), if the bail bond agency is licensed under this chapter as of December 31, 1999, a verified [current] financial statement for the current year:~~ ~~(I) reviewed by a certified public accountant; and~~ ~~(II) showing a minimum net worth of [at least] $250,000, at least $50,000 of which is in liquid assets.~~ ~~(ii) a copy of the applicant's federal and state income tax returns for the preceding two years, but only for an original application; and~~ ~~(iii) for each parcel of real property owned by the applicant and included in net worth calculations:~~ ~~(A) a title letter or report, or a current abstract of title from the office of the county recorder; and~~	***Policy change:*** The amendments to subsection (2) streamline the licensing process for a bail bond agency that is backed by property it owns. Although the amendments add a requirement that the CPA-reviewed financial statement be verified, they remove the requirements that a license applicant submit tax returns, title letters or reports, abstracts of title, appraisal reports, or tax notices. The amendments also reduce the time that Department staff will spend reviewing a license application.

	~~(B)(I) a certified appraisal made not more than six months prior to licensure for each parcel and a title report that is current as of the date of licensure, if the bail bond agency is in its first year of licensure and has pledged real property owned by the applicant; or~~ ~~(II) a certified appraisal report or a current tax notice and a title letter or report, or a current abstract of title from the county recorder if the bail bond agency is in its second or subsequent year of licensure and has pledged real property owned by the applicant.~~] (b) For purposes of this Subsection (2), only real or personal property located in Utah may be included in the net worth of the bail bond agency. (3) A bail bond agency shall maintain a qualifying power of attorney issued by a surety insurer if: (a) the bail bond agency is the agent of the surety insurer; and (b) the surety insurer: (i) sells bail bonds; (ii) is in good standing in its state of domicile; and (iii) is granted a certificate to write bail bonds in Utah. (4) The commissioner may revoke the license of a bail bond agency that fails to maintain the minimum financial requirements required under this section. (5) The commissioner may set by rule the limits on the aggregate amounts of bail bonds issued by a bail bond agency.	
Lines	**Amendment text**	**Nature of change**
3443-3487	**31A-35-406. Initial licensing, license renewal and license reinstatement.** (1) An applicant for an initial bail bond agency license shall: (a) complete and submit to the department an application; (b) submit to the department, as applicable, a copy of the applicant's: (i) irrevocable letter of credit, as required under Subsection 31A-35-404(1); (ii) verified financial statement, as required under Subsection 31A-35-404(2); or (iii) qualifying power of attorney, as required under Section 31A-35-404(3); and (c) pay the department the applicable initial license fee established in accordance with Section 31A-3-103. ([~~1~~]) (2) (a) A license under this chapter expires annually effective at midnight on August 14. (b) To renew [~~its~~] bail bond agency license under this chapter, on or before July 15 a bail bond agency shall: (i) complete and submit to the department a renewal application [~~to the department;~~] that includes certification that: (A) a principal of the agency attended or participated by telephone in at least one entire board meeting during the twelve-month period prior to July 15; and	***Policy change and codifies practice:*** The amendments reflect the proposed policy changes and practice codifications in Section 31A-35-404 above. The amendments mean that an agency must do the following to renew or reinstate a license: • Submit an application in which it certifies attendance at a Board meeting and compliance with bond limits; • Submit a current irrevocable letter of credit, a verified financial statement reviewed by

	(B) as of May 1, the agency complies with aggregate bond limits established by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; [~~require that a principal of the agency attends at least one board meeting each year; and~~] (ii) submit to the department, as applicable, a copy of the applicant's: (A) irrevocable letter of credit, as required under Subsection 31A-35-404(1); (B) verified financial statement, as required under Subsection 31A-35-404(2); or (C) qualifying power of attorney, as required under Subsection 31A-35-404(3); and (iii) pay the department the applicable renewal fee established in accordance with Section 31A-3-103. [~~(b)~~] (c) A bail bond agency shall renew [~~its~~] the bail bond agency's license under this chapter annually as established by department rule, regardless of when the license is issued. [~~(2)~~](3)(a) A bail bond agency may apply for reinstatement of an expired bail bond agency license within one year [following the expiration of the license under Subsection (1) by:] after the day on which the license expires by complying with the renewal requirements described in Subsection (2). [~~(a) submitting the renewal application required by Subsection (1); and~~ ~~(b) paying a license reinstatement fee established in accordance with Section 31A-3-103.~~] [(~~3~~)] (b) If a bail bond agency license has been expired for more than one year, the person applying for reinstatement of the bail bond agency license shall[~~:~~]comply with the initial licensing requirements described in Subsection (1). [~~(a) submit a new application form to the commissioner; and~~ ~~(b) pay the application fee established in accordance with Section 31A-3-103~~]. (4) If a bail bond agency license is suspended, the applicant may not submit an application for a bail bond agency license until after [the end of] the day on which the period of suspension ends. (5) The department shall deposit a fee collected under this section shall be deposited in the restricted account created in Section 31A-35-407.	a certified public accountant, or a current qualifying power of attorney, as applicable; and • Pay the licensing fee.
Lines	**Amendment text**	**Nature of change**
	31A-37-102. Definitions. As used in this chapter: (1) (a) "Affiliated company" means a business entity that because of common ownership, control, operation, or management is in the same corporate or limited liability company system as: (i) a parent; (ii) an industrial insured; or (iii) a member organization.	

	(b) [~~Notwithstanding Subsection (1)(a), the commissioner may issue~~] "Affiliated company" does not include a business entity for which the commissioner issues an order finding that [~~a~~] the business entity is not an affiliated company. (2) "Alien captive insurance company" means an insurer: (a) formed to write insurance business for a parent or affiliate of the insurer; and (b) licensed pursuant to the laws of an alien or foreign jurisdiction that imposes statutory or regulatory standards: (i) on a business entity transacting the business of insurance in the alien or foreign jurisdiction; and (ii) in a form acceptable to the commissioner. (3) "Applicant captive insurance company" means an entity that has submitted an application for a certificate of authority for a captive insurance company, unless the application has been denied or withdrawn. (4) "Association" means a legal association of two or more persons that has been in continuous existence for at least one year if: (a) the association or its member organizations: (i) own, control, or hold with power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer; or (ii) have complete voting control over an association captive insurance company incorporated as a mutual insurer; (b) the association's member organizations collectively constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer; or (c) the association or [~~its~~] the association's member organizations have complete voting control over an association captive insurance company formed as a limited liability company. (5) "Association captive insurance company" means a business entity that insures risks of: (a) a member organization of the association; (b) an affiliate of a member organization of the association; and (c) the association. (6) "Branch business" means an insurance business transacted by a branch captive insurance company in this state. (7) "Branch captive insurance company" means an alien captive insurance company has a certificate of authority from the commissioner to transact the business of insurance in this state through a captive insurance company that is domiciled outside of this state.	

3533-3535	(8) "Branch operation" means a business operation of a branch captive insurance company in this state. (9)(a) "Captive insurance company" means the same as that term is defined in Section 31A-1-301. (b) "Captive insurance company" includes any of the following formed or holding a certificate of authority under this chapter: (i) a branch captive insurance company; (ii) a pure captive insurance company; (iii) an association captive insurance company; (iv) a sponsored captive insurance company; (v) an industrial insured captive insurance company, including an industrial insured captive insurance company formed as a risk retention group captive in this state pursuant to the provisions of the Federal Liability Risk Retention Act of 1986; (vi) a special purpose captive insurance company; or (vii) a special purpose financial captive insurance company. *****	***Technical change:*** The Insurance Code now contains two separate definitions of the term "captive insurance company." This amendment coordinates the two definitions.
Lines	**Amendment text**	**Nature of change**
3678-3679	**31A-37-204. Paid-in capital -- Other capital.** (1)(a) The commissioner may not issue a certificate of authority to a company described in Subsection (1)(c) unless the company possesses and thereafter maintains unimpaired paid-in capital and unimpaired paid-in surplus of: ***** (iv) in the case of a sponsored captive insurance company, not less than [~~$1,000,000~~]$500,000, of which a minimum of [~~$350,000~~] $200,000 is provided by the sponsor; *****	***Policy change:*** The current law requires paid in capital and surplus for a sponsored captive insurer to be $1M, at least $350K of which is paid by the sponsor. The amendment reduces those amounts to $500K and $200K respectively. The reduction maintains Utah's competitive status as the second-ranked state for licensed captive insurers.
Lines	**Amendment text**	**Nature of change**
3768-3784	**31A-37-303. Reinsurance.** (1)(a) A captive insurance company may cede risks to any insurance company approved by the commissioner. (b) A captive insurance company may provide reinsurance[~~, as authorized in this title,~~]on risks ceded by any other insurer with prior approval of the commissioner. *****	***Codifies practice:*** This amendment makes it clear that this code section, not another code provision, authorizes a captive insurance company to reinsure risks.

Lines	Amendment text	Nature of change
3791-3850	**31A-45-501. Access to health care providers.** (1) As used in this section: (a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification category established under Title 58, Occupations and Professions, or within the same facility licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act. (b) "Covered health care services" or "covered services" means health care services for which an enrollee is entitled to receive under the terms of a [~~health maintenance~~] managed care organization contract. (c) "Credentialed staff member" means a health care provider with active staff privileges at an independent hospital or federally qualified health center. (d) "Federally qualified health center" means as defined in the Social Security Act, 42 U.S.C. Sec. 1395x. (e) "Independent hospital" means a general acute hospital or a critical access hospital that: (i) is either: (A) located 20 miles or more from any other general acute hospital or critical access hospital; or (B) licensed as of January 1, 2004; (ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and (iii) is controlled by a board of directors of which 51% or more reside in the county where the hospital is located and: (A) the board of directors is ultimately responsible for the policy and financial decisions of the hospital; or (B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part, by an entity that owns or controls a health maintenance organization if the hospital is a contracting facility of the organization. (f) "Noncontracting provider" means an independent hospital, federally qualified health center, or credentialed staff member that has not contracted with a managed care organization to provide health care services to enrollees of the managed care organization. (2) Except for a managed care organization that is under the common ownership or control of an entity with a hospital located within 10 paved road miles of an independent hospital, a managed care organization shall pay for covered health care services rendered to an enrollee by an independent hospital, a credentialed staff member at an independent hospital, or a credentialed staff member at his local practice location if:	***Technical change:*** During the 2017 General Session, HB336 Health Reform Amendments was passed. During the drafting, two areas were missed from changing the term health maintenance organization to managed care organization.

	(a) the enrollee: (i) lives or resides within 30 paved road miles of the independent hospital; or (ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the independent hospital than a contracting hospital; (b) the independent hospital is located prior to December 31, 2000 in a county with a population density of less than 100 people per square mile, or the independent hospital is located in a county with a population density of less than 30 people per square mile; and (c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the managed care organization contract. (3) A managed care organization shall pay for covered health care services rendered to an enrollee at a federally qualified health center if: (a) the enrollee: (i) lives or resides within 30 paved road miles of the federally qualified health center; or (ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the federally qualified health center than a contracting provider; (b) the federally qualified health center is located in a county with a population density of less than 30 people per square mile; and (c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the managed care organization contract. (4)(a) A managed care organization shall reimburse a noncontracting provider or the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as it pays to contracting providers under a noncapitated arrangement for comparable services. (b) A managed care organization shall reimburse a federally qualified health center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as paid by the managed care organization under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the service. (5)(a) A noncontracting independent hospital may not balance bill a patient when the [~~health maintenance~~] <u>managed care</u> organization reimburses a noncontracting independent hospital or an enrollee in accordance with Subsection (4)(a). (b) A noncontracting federally qualified health center may not balance bill a patient when the federally qualified health center or the enrollee receives reimbursement in accordance with Subsection (4)(b). *****	