Utah Insurance Department
2022 Legislative Session
HB0031 S01, Insurance Amendments
Proposed amendments and nature of changes

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
	31A-1-301. Definitions. As used in this title, unless otherwise specified: (1)(a) "Accident and health insurance" means insurance to provide protection against economic losses resulting from: (i) a medical condition, including: (A) a medical care expense; or (B) the risk of disability; (ii) accident; or (iii) sickness. (b) "Accident and health insurance": (i) includes a contract with disability contingencies including: (A) an income replacement contract; (B) a health care contract;	
450	(C) a[~~n expense reimbursement~~]fixed indemnity contract;	***Codifies practice:*** Refer to proposed changes to 31A-1-301(65).
	(D) a credit accident and health contract; (E) a continuing care contract; and (F) a long-term care contract; and (ii) may provide: (A) hospital coverage; (B) surgical coverage; (C) medical coverage; (D) loss of income coverage; (E) prescription drug coverage; (F) dental coverage; or (G) vision coverage. (c) "Accident and health insurance" does not include workers' compensation insurance. (d) For purposes of a national licensing registry, "accident and health insurance" is the same as	

728-740	"accident and health or sickness insurance." ***** (3) "Administrator" means the same as that term is defined in Subsection ~~[(178)~~] (182). ***** (4) "Adult" means an individual who [~~has attained the age of at least 18 years~~] is 18 years old or older. ***** (50) "Disability income insurance" means the same as that term is defined in Subsection [~~(85)~~] (86). ***** (53) (a) "Eligible employee" means: (i) an employee who: (A) works on a full-time basis; and (B) has a normal work week of 30 or more hours; or (ii) a person described in Subsection (53)(b). (b) "Eligible employee" includes: [~~(i) an owner who:~~] [~~(A) works on a full-time basis;~~] [~~(B) has a normal work week of 30 or more hours; and~~] [~~(C) employs at least one common employee; and~~] [~~(ii) if the individual is included under a health benefit plan of a small employer:~~] [~~(A) a sole proprietor;~~] [~~(B) a partner in a partnership; or~~] [~~(C) an independent contractor.~~] (i) an owner, sole proprietor, or partner who: (A) works on a full-time basis; (B) has a normal work week of 30 or more hours; and (C) employs at least one common employee; and (ii) an independent contractor if the individual is included under a health benefit plan of a small employer. (c) "Eligible employee" does not include, unless eligible under Subsection (53)(b): (i) an individual who works on a temporary or substitute basis for a small employer; (ii) an employer's spouse who does not meet the requirements of Subsection (53)(a)(i); or (iii) a dependent of an employer who does not meet the requirements of Subsection (53)(a)(i).	***Policy change:*** Requires insurer to provide coverage to sole proprietors or partners who meet the standards of an eligible employee.

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747- 755	(54) "Emergency medical condition" means a medical condition that: (a) manifests itself by acute symptoms, including severe pain; and (b) would cause a prudent layperson possessing an average knowledge of medicine and health to reasonably expect the absence of immediate medical attention through a hospital emergency department to result in: (i) placing the layperson's health or the layperson's unborn child's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.	***Technical change:*** Moves the term "emergency medical condition" from 31A-22-627 so the term is used consistently.
758	*****	
	[~~(54)~~] (55) "Employee" means: (a) an individual employed by an employer; [~~and~~] or (b) an [~~owner~~] individual who meets the requirements of Subsection (53)(b)[~~(i)~~].	
826-831	***** [~~(65) "Expense reimbursement insurance" means insurance:~~ ~~(a) written to provide a payment for an expense relating to hospital confinement resulting from illness or injury; and~~ ~~(b) written:~~ ~~(i) as a daily limit for a specific number of days in a hospital; and~~ ~~(ii) to have a one or two day waiting period following a hospitalization.~~]	***Codifies practice:*** Updating the term that is more commonly used in industry and to include all types of fixed indemnity coverage.
864-866	***** (70) (a) "Fixed indemnity insurance" means accident and health insurance written to provide a fixed amount for a specified event relating to or resulting from an illness or injury. (b) "Fixed indemnity insurance" includes hospital confinement indemnity insurance.	
919-922	***** [~~(79)~~](80) (a) "Health benefit plan" means[~~, except as provided in Subsection [(79)(b)]~~ a policy, contract, certificate, or agreement offered or issued by an insurer [~~health carrier~~]to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care, including major medical expense coverage. (b) "Health benefit plan" does not include: (i) coverage only for accident or disability income insurance, or any combination thereof; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit-only insurance; (vii) coverage for on-site medical clinics;	***Technical change:*** The term "health carrier" is undefined. Changed to "insurer" for consistency with other uses of the term in Title 31A. Changed hospital confinement indemnity to fixed indemnity based on the proposed change in definition. Clarified a health benefit plan is major medical expense coverage.

	(viii) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits; (ix) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: (A) limited scope dental or vision benefits; (B) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or (C) other similar limited benefits, specified in federal regulations issued pursuant to Pub. L. No. 104-191; (x) the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of benefits and any exclusion of benefits under any health plan, and the benefits are paid with respect to an event without regard to whether benefits are provided under any health plan: (A) coverage only for specified disease or illness; or	
948	(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; (xii) short-term limited duration health insurance; and (xiii) student health insurance, except as required under 45 C.F.R. Sec. 147.145. *****	
1089	[~~(100)~~](101) (a) "Insurer", "carrier", “insurance carrier” or "insurance company" means a person doing an insurance business as a principal including: (i) a fraternal benefit society; (ii) an issuer of a gift annuity other than an annuity specified in Subsections 31A-22-1305(2) and (3); (iii) a motor club; Utah Code Page 21 (iv) an employee welfare plan; (v) a person purporting or intending to do an insurance business as a principal on that person's own account; and (vi) a health maintenance organization. (b) "Insurer," "carrier," "insurance carrier," or "insurance company" does not include a governmental entity. *****	***Codifies practice:*** The Insurance Department’s rules and the Insurance Code use the terms "carrier", “insurance carrier” and "insurance company" as a substitute for “insurer”. Adding the terms to the definition makes it clear that "insurer", "carrier", “insurance carrier” and "insurance company" have the same meaning.

	[~~(117)~~](118)(a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage: (i) in a setting other than an acute care unit of a hospital; (ii) for not less than 12 consecutive months for a covered person on the basis of: (A) expenses incurred; (B) indemnity; (C) prepayment; or (D) another method; (iii) for one or more necessary or medically necessary services that are: (A) diagnostic; (B) preventative; (C) therapeutic; (D) rehabilitative; (E) maintenance; or (F) personal care; and (iv) that may be issued by: (A) an insurer; (B) a fraternal benefit society; (C)(I) a nonprofit health hospital; and (II) a medical service corporation; (D) a prepaid health plan; (E) a health maintenance organization; or (F) an entity similar to the entities described in Subsections (117)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance. (b) "Long-term care insurance" includes: (i) any of the following that provide directly or supplement long-term care insurance: (A) a group or individual annuity or rider; or (B) a life insurance policy or rider; (ii) a policy or rider that provides for payment of benefits on the basis of: (A) cognitive impairment; or (B) functional capacity; or (iii) a qualified long-term care insurance contract. (c) "Long-term care insurance" does not include: (i) a policy that is offered primarily to provide basic Medicare supplement coverage; (ii) basic hospital expense coverage; (iii) basic medical/surgical expense coverage; (iv) hospital confinement indemnity coverage;	

	(v) major medical expense coverage; (vi) income replacement or related asset-protection coverage; (vii) accident only coverage; (viii) coverage for a specified: (A) disease; or (B) accident; (ix) limited benefit health coverage; (x) a life insurance policy that accelerates the death benefit to provide the option of a lump sum payment: (A) if the following are not conditioned on the receipt of long-term care: (I) benefits; or (II) eligibility; and (B) the coverage is for one or more the following qualifying events: (I) terminal illness; (II) medical conditions requiring extraordinary medical intervention; or (III) permanent institutional confinement[~~.~~]; or	***Technical change:*** Clarifies limited long-term care insurance is not considered long-term care insurance.
1268	(xi) limited long-term care as defined in Section 31A-22-2002. *****	
1309- 1314	(128) “NAIC" means the National Association of Insurance Commissioners. (129) "NAIC liquidity stress test framework" means a NAIC publication that includes: (a) a history of the NAIC's development of regulatory liquidity stress testing; (b) the scope criteria applicable for a specific data year; and (c) the liquidity stress test instructions and reporting templates for a specific data year, as adopted by the NAIC and as amended by the NAIC in accordance with NAIC procedures. *****	***Policy Change:*** The definitions in (128), (129) and (169) are part of new financial regulation laws that are proposed in 31A-16-105, -106 and -109.
1480	[~~(156)~~] (159) (a) [~~Except as provided in Subsection (156)(b), "rate~~] "Rate service organization" means a person who assists an insurer in rate making or filing by: (i) collecting, compiling, and furnishing loss or expense statistics; (ii) recommending, making, or filing rates or supplementary rate information; or (iii) advising about rate questions, except as an attorney giving legal advice. (b) "Rate service organization" does not [~~mean~~] include: (i) an employee of an insurer; (ii) a single insurer or group of insurers under common control; 1461 (iii) a joint underwriting group; or (iv) an individual serving as an actuarial or legal consultant *****	***Technical change:*** This amendment removes unnecessary words.

1545- 1547	(169) "Scope Criteria" means the designated exposure bases and their minimum magnitudes for a specified data year that are used to establish a preliminary list of insurers considered scoped into the NAIC Liquidity Stress Test Framework for that data year. *****	
1584- 1604	[~~(169)~~] (173) (a) "Self-insurance" means an arrangement under which a person provides for spreading [~~its own~~] the person's own risks by a systematic plan. (b) "Self-insurance" includes: (i) an arrangement under which a governmental entity undertakes to indemnify an employee for liability arising out of the employee's employment; and (ii) an arrangement under which a person with a managed program of self-insurance and risk management undertakes to indemnify the person's affiliate, subsidiary, director, officer, or employee for liability or risk that arises out of the person's relationship with the affiliate, subsidiary, director, officer, or employee. [~~(b) Except as provided in this Subsection (169), "self-insurance"~~] (c) "Self-insurance" does not include: (i) an arrangement under which a number of persons spread their risks among themselves[~~.~~]; or (ii) an arrangement with an independent contractor. [~~(c) "Self-insurance" includes:~~] [~~(i) an arrangement by which a governmental entity undertakes to indemnify an employee for liability arising out of the employee's employment; and~~] [~~(ii) an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or employees for liability or risk that is related to the relationship or employment.~~] [~~(d) "Self-insurance" does not include an arrangement with an independent contractor.~~]	
Lines	**Amendment text**	**Nature of change**
1756- 1758	**31A-2-210 Participation in organizations.** (1) The commissioner and the Insurance Department shall maintain close relations with the commissioners of other states and shall participate in the activities and affairs of the National Association of Insurance Commissioners and other organizations to the extent, in the commissioner's judgment, these activities will promote the purposes of the Insurance Code. The actual and necessary expenses incurred by this participation shall be paid out of the Insurance Department appropriation. The commissioner may not make any commitments that are not terminable on reasonable notice by the commissioner. (2) The commissioner shall participate in or provide support for participation in a professional organization that represents states or legislatures and whose purposes are to preserve state jurisdiction over the business of insurance.	***Codifies practice:*** Assures the Department will continue its efforts to preserve state regulation of the business of insurance.

Lines	Amendment text	Nature of change
1822-1829	**31A-2-403. Title and Escrow Commission created.** ***** (6)(a)(i) Except as provided in Subsection (6)(b), the commission shall meet at least monthly. (ii)(A) The commissioner shall, with the concurrence of the chair of the commission, designate [~~at least~~] one monthly meeting per calendar year [~~quarter~~] as an in-person meeting. [~~(B) Notwithstanding Section 52-4-207, a commission member shall physically attend a meeting designated as an in-person meeting under Subsection (6)(a)(ii)(A) and may not attend through electronic means. A commission member may attend any other commission meeting, subcommittee meeting, or emergency meeting by electronic means in accordance with Section 52-4-207.~~] (B) A commission member may, after providing advance notice to the commissioner, attend an in-person meeting through electronic means. (b) (i) Except as provided in Subsection (6)(b)(ii), the commissioner may, with the concurrence of the chair of the commission, cancel a monthly meeting of the commission if, due to the number or nature of pending title insurance matters, the monthly meeting is not necessary. (ii) The commissioner may not cancel a monthly meeting designated as an in-person meeting under Subsection (6)(a)(ii)(A). (c) The commissioner may call additional meetings: (i) at the commissioner's discretion; (ii) upon the request of the chair of the commission; or (iii) upon the written request of three or more commission members. (d)(i) Three commission members constitute a quorum for the transaction of business. (ii) The action of a majority of the commission members when a quorum is present is the action of the commission.	***Policy change:*** The amendment provides for greater geographical diversity on the Title and Escrow Commission by allowing members to attend meetings through electronic means.
Lines	**Amendment text**	**Nature of change**
1846-1901	**31A-4-115 Plan of orderly withdrawal.** (1) As used in this section, a "line of insurance" means: (a) a general line of authority; (b) a general line of insurance; (c) a limited line insurance; (d) the small employer group health benefit plan market when there is a discontinuance of all small employer health benefit plans under Subsection 31A-22-618.6(5)(e); (e) the large employer group health benefit market when there is a discontinuance of all large employer health benefit plans under Subsection 31A-22-618.6(5)(e); or (f) the individual health benefit plan market when there is a discontinuance of all	***Technical change:*** This amendment clarifies what is considered as an insurer's withdrawal from the market. It provides that an insurer that withdraws from offering one line of insurance is not prohibited from offering insurance in another line.

	individual health benefit plans under Subsection 31A-22-618.7(3)(e). [~~(1) (a)~~] (2) When an insurer intends to withdraw from writing a line of insurance in this state or to reduce its total annual premium volume by 75% or more, the insurer shall file with the commissioner a plan of orderly withdrawal. [~~(b) For purposes of this section, a discontinuance of a health benefit plan is a withdrawal from a line of insurance under Subsections 31A-22-618.6(5) or 31A-22-618.7(3).~~] [~~(2)~~] (3) An insurer's plan of orderly withdrawal shall: (a) indicate the date the insurer intends to: (i) begin the withdrawal plan; and (ii) complete [~~its~~] the withdrawal plan; and (b) include provisions for: (i) meeting the insurer's contractual obligations; (ii) providing services to [~~its~~] the insurer's Utah policyholders and claimants; (iii) meeting applicable statutory obligations; and (iv) the payment of a withdrawal fee of $50,000 to the department if the insurer's line of [~~business~~]insurance is not assumed or placed with another insurer approved by the commissioner. [~~(3)~~](4) The commissioner shall approve a plan of orderly withdrawal if the plan of orderly withdrawal adequately demonstrates that the insurer will: (a) protect the interests of the people of the state; (b) meet the insurer's contractual obligations; (c) provide service to the insurer's Utah policyholders and claimants; and (d) meet applicable statutory obligations. [~~(4)~~](5) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for orderly withdrawal. [~~(5)~~](6) The commissioner may require an insurer to increase the deposit maintained in accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in the name of the commissioner upon finding, after an adjudicative proceeding that: (a) there is reasonable cause to conclude that the interests of the people of the state are best served by such action; and (b) the insurer: (i) has filed a plan of orderly withdrawal; or (ii) intends to: (A) withdraw from writing a line of insurance in this state; or (B) reduce the insurer's total annual premium volume by 75% or more. [~~(6)~~](7) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:	

	(a) withdraws from writing a line of insurance in this state without receiving the commissioner's approval of a plan of orderly withdrawal; or (b) reduces [~~its~~] the insurer's total annual premium volume by 75% or more in any year without receiving the commissioner's approval of a plan of orderly withdrawal. [~~(7)~~](8) An insurer that withdraws from writing [~~all lines~~] a line of insurance in this state may not resume writing the line of insurance in this state for five years unless the commissioner finds that the prohibition should be waived because the waiver is: (a) in the public interest to promote competition; or (b) to resolve inequity in the marketplace. [~~(8)~~](9) The commissioner shall adopt rules necessary to implement this section.	
Lines	**Amendment text**	**Nature of change**
2008-2009	**31A-5-506. Conversion of a domestic mutual into a stock corporation.** ***** (12) This section does not apply to a mutual reorganization or merger under Section 31A-16-102.6.	***Policy change:*** See 31A-16-102.6
Lines	**Amendment text**	**Nature of change**
2064	**31A-6a-104. Required disclosures.** ***** (3)(a) A service contract and a vehicle protection product warranty shall: (i) conspicuously state the name, address, and a toll free claims service telephone number of the reimbursement insurer; (ii)(A) identify the service contract provider, the seller, and the service contract holder; or (B) identify the warrantor, the seller, and the warranty holder; (iii) conspicuously state the total purchase price and the terms under which the service contract or warranty is to be paid; (iv) conspicuously state the existence of any deductible amount or service fee; (v) specify the merchandise, service to be provided, and any limitation, exception, or exclusion; (vi) state a term, restriction, or condition governing the transferability of the service contract or warranty; and (vii) state a term, restriction, or condition that governs cancellation of the service contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder or service contract provider. (b) Beginning January 1, 2021, a service contract shall contain a conspicuous statement in substantially the following form: "Purchase of this product is optional and is not required in order to finance, lease, or purchase a motor vehicle."	***Codifies practice:*** Industry practice is to refer to a deductible as a "service fee". The amendment makes it clear that § 31A-6a-104(3)(a)(iv) applies to a service fee.

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Lines	**Amendment text**	**Nature of change**
2109-2218	**31A-16-102.6. Mutual Insurance Holding Companies.** (1) The following definitions apply in this Section: (a)(i) "Intermediate holding company" means a holding company that: (A) is a subsidiary of a mutual insurance holding company; and (B) directly or through a subsidiary intermediate holding company holds one or more subsidiary insurers, including a reorganized insurer, of which a majority of the voting shares of the capital stock would otherwise have been required pursuant to this section to be at all times owned by the mutual insurance holding company. (b)(i) "Majority of the voting shares of the capital stock of the reorganized insurer" means shares of the capital stock of the reorganized insurer that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the reorganized insurer for the election of directors and on all other matters submitted to a vote of the shareholders of the reorganized insurer. (ii) The ownership of a majority of the voting shares of the capital stock of the reorganized insurer includes indirect ownership through one or more intermediate holding companies in a corporate structure approved by the commissioner. However, indirect ownership through one or more intermediate holding companies may not result in the mutual insurance holding company owning less than the equivalent of the majority of the voting shares of the capital stock of the reorganized insurer. (2)(a) With the commissioner's approval, a domestic mutual insurer may reorganize by forming an insurance holding company system in which: (i) the membership interests of the policyholders of the domestic mutual insurer become membership interests in the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company; and (ii) the domestic mutual insurer is reorganized as a domestic stock insurance company. (b) The commissioner has discretion to approve the reorganization if: (i) the plan properly protects the interests of the policyholders; (ii) the plan is fair and equitable to the policyholders; (iii) the plan satisfies the requirements of Subsections (8) through (10) of Section 31A-16-103;	***Policy change:*** This amendment allows a mutual insurer to access capital markets by creating a holding company owned by the mutual members and a stock company that can be used to raise capital.

	(iv) all initial shares of the capital stock of the reorganized insurer are issued to the mutual insurance holding company or to an intermediate holding company; and (v) the mutual insurance holding company or an intermediate holding company owns a majority of the voting shares of the capital stock of the reorganized insurer at all times. (c) The commissioner may require modifications of the plan of reorganization as a condition of approval in order to protect the policyholders' interests. (d) The commissioner may retain, at the reorganizing insurer's expense, third-party consultants as the commissioner determines are reasonably necessary to assist in reviewing the reorganization plan. (e) The commissioner has jurisdiction over a mutual insurance holding company organized pursuant to this Section, and over an intermediate holding company as if it were a mutual insurance holding company, to assure that the reorganizing insurer's policyholder interests are protected. (f) Subject to the commissioner's approval, the reorganized insurer or a stock insurance subsidiary within the mutual insurance holding company may issue dividends or distributions to the mutual insurance holding company or an intermediate holding company. (3)(a) With the commissioner's approval, a foreign mutual insurer that would qualify to become a domestic insurer organized under the laws of this state may reorganize by forming an insurance holding company system in which: (i) the policyholders' membership interests in the foreign mutual insurer become membership interests in the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company; and (ii) the foreign mutual insurer is reorganized as a foreign stock insurance company. (b) The commissioner has discretion to approve the proposed plan of reorganization if: (i) the plan complies with the requirements of any law or rule applicable to the foreign mutual insurer; (ii) the plan propertly protects the interests of the policyholders; (iii) the plan is fair and equitable to the policyholders; (iv) the plan satisfies the requirements of Subsections (8) through (10) of Section 31A-16-103; (v) all initial shares of the capital stock of the reorganizing insurer are issued to the mutual insurance holding company or to an intermediate holding company; and	

	(vi) the mutual insurance holding company or an intermediate holding company owns a majority of the voting shares of the capital stock of the reorganizing insurer at all times. (c) The commissioner may require modifications of the plan of reorganization as a condition of approval in order to protect the policyholders' interests. (d) The commissioner may retain, at the insurer's expense, third-party consultants as are reasonably necessary to assist reviewing the reorganization plan. (e) The reorganizing foreign mutual insurer may remain a foreign corporation after the merger and may be admitted to conduct business in this state on the commissioner's approval. (f) A foreign mutual insurer that is a party to plan of reorganization may at the same time redomesticate in this state by complying with the applicable requirements of this state and its state of domicile. (4) (a) A mutual insurance holding company resulting from the reorganization of a domestic mutual insurer must be incorporated pursuant to Chapter 5, Title 31A, Utah Insurance Code, subject to this Section controlling any conflicting provisions contained in that Chapter. (b) The articles of incorporation and the bylaws of the mutual insurance holding company are subject to approval of the commissioner in the same manner as those of an insurance company. (5)(a) A mutual insurance holding company is subject to Title 31A, Chapter 27a, Insurer Receivership Act, and will automatically be a party to any proceeding under that chapter involving an insurer that, as a result of a reorganization pursuant to subsection (2) or (3) of this Section, is a subsidiary of the mutual insurance holding company. (b) In a proceeding under Title 31A, Chapter 27a, Insurer Receivership Act, involving the reorganized insurer, the assets of the mutual insurance holding company are deemed to be assets of the estate of the reorganized insurer for purposes of satisfying the claims of the reorganized insurer's policyholders. (c) A mutual insurance holding company may not be dissolved or liquidated without the prior approval of the commissioner or as ordered by the district court pursuant to Title 31A, Chapter 27a, Insurer Receivership Act. (6)(a) Section 31A-5-506 does not apply to a reorganization or merger pursuant to this section. (b) Section 31A-5-506 applies to demutualization of a mutual insurance holding company. (7) A membership interest in a domestic mutual insurance holding company does not constitute a security under Utah law.	

	(8) (a) The majority of the voting shares of the capital stock of the reorganized insurer may not be sold, transferred, assigned, pledged, subject to a security interest or lien, encumbered, hypothecated, or alienated by the mutual insurance holding company or an intermediate holding company. (b) Any sale, transfer, assignment, pledge, security interest, lien, encumbrance, hypothecation, or alienation of, in, or on the majority of the voting shares of the reorganized insurer is void in inverse chronological order of the date of such sale, transfer, assignment, pledge, security interest, lien, encumbrance, hypothecation, or alienation, as to the shares necessary to constitute a majority of the voting shares. (c) The majority of the voting shares of the capital stock of the reorganized insurer may not be subject to execution and levy under Utah law. (d) The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two or more reorganized insurers or two or more intermediate holding companies that were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions, and limitations as provided in this section to which the shares of the merging or consolidating reorganized insurers or intermediate holding companies were subject to prior to the merger or consolidation. (9) The commissioner may make rules under Title 63G, Chapter 3 to implement the provisions of this Section.	
Lines	**Amendment text**	**Nature of change**
2318-2399	**31A-16-105** ***** (13) (a) The ultimate controlling person of an insurer subject to registration shall concurrently file with the registration an annual group capital calculation report as directed by the lead state commissioner. (b) The annual group capital calculation report described in Subsection (13)(a) shall be filed with the lead state commissioner of the insurance holding company system as determined by the commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC. (c) Subject to Subsections (13)(d) and (e), the following insurance holding company systems are exempt from filing the annual group capital calculation report described in Subsection (13)(a): (i) an insurance holding company system that: (A) has only one insurer within the insurance holding company's structure;	***Policy change:*** The amendments to this section implement a requirement that large insurance holding companies submit to the Insurance Department a Group Capital Calculation (GCC) and the results of a Liquidity Stress Test (LST). The requirement assures that solvency-related information is provided to the Department. Although Utah's current domestic insurers are not sufficiently large to be subject to the requirement, the

	(B) writes business and is licensed only in the insurance holding company system's domestic state; and (C) assumes no business from any other insurer; (ii) an insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board unless: (A) the lead state commissioner requests the calculation from the Federal Reserve Board under the terms of information sharing agreements in effect; and (B) the Federal Reserve Board cannot share the calculation with the lead state commissioner; (iii) an insurance holding company system whose non-United States group-wide supervisor is located within a reciprocal jurisdiction as described in Subsection 31A-17-404(8) that recognizes the United States' state regulatory approach to group supervision and group capital; and (iv) an insurance holding company system: (A) that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined the information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook; and (B) whose non-United States group-wide supervisor that is not located in a reciprocal jurisdiction recognizes and accepts, as specified by the lead state commissioner in regulation, the group capital calculation as the world-wide group capital assessment for United States insurance groups that operate in that jurisdiction. (d) If, after consultation with other supervisors or officials, the lead state commissioner determines appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace, the lead state commissioner shall require the group capital calculation for United States operations of any non-United States based insurance holding company system. (e) The lead state commissioner may: (i) exempt the ultimate controlling person from filing the annual group capital calculation; or (ii) accept a limited group capital filing or report in accordance with criteria as specified by the lead state commissioner in regulation. (f) If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group capital calculation at the next annual filing date unless the lead state commissioner gives an extension based on reasonable grounds. (14) (a) The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC liquidity stress test framework shall file the results of a specific year's liquidity stress	Department seeks its adoption because the National Association of Insurance Commissioners mandates that the GCC be adopted for accreditation and strongly encourages adoption of the LST.

	test. (b) The filing described in Subsection (14)(a) shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC. (c) Any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured shall be effective on January 1 of the year following the calendar year in which the change is adopted. (d) Insurers meeting at least one threshold of the NAIC liquidity stress test framework's scope criteria are scoped into the NAIC liquidity stress test framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, determines the insurer should not be scoped into the NAIC liquidity stress test framework for that data year. (e) Insurers that do not meet at least one threshold of the NAIC liquidity stress test framework's scope criteria are scoped out of the NAIC liquidity stress test framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, determines the insurer should be scoped into the NAIC liquidity stress test framework for that data year. (f) To avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis, the lead state insurance commissioner, in consultation with the Financial Stability Task Force or the NAIC Financial Stability Task Force's suc cessor, shall assess this concern as part of the lead state insurance commissioner's determination of whether an insurer is scoped into the NAIC liquidity stress test framework for a specified data year. (g) The performance of, and filing of the results from, a specific year's liquidity stress test shall comply with: (i) the NAIC liquidity stress test framework instructions and reporting templates for that year; and (ii) lead state insurance commissioner determinations made in conjunction with the NAIC Financial Stability Task Force or the NAIC Financial Stability Task Force's successor, provided within the NAIC liquidity stress test framework. [(~~13~~)] (15) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for the filing is a violation of this section.	
Line	**Amendment text**	**Nature of change**
	31A-16-106. Standards and management of an insurer within a holding company system. (1)(a) Transactions within an insurance holding company system to which an insurer subject to registration is a party are subject to the following standards: (i) the terms shall be fair and reasonable;	

2422-2445	(ii) agreements for cost sharing services and management shall include the provisions required by rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; (iii) charges or fees for services performed shall be reasonable; (iv) expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied; (v) the books, accounts, and records of each party to all transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including the accounting information necessary to support the reasonableness of the charges or fees to the respective parties; [~~and~~] (vi) the insurer's surplus held for policyholders, following any dividends or distributions to shareholder affiliates, shall be reasonable in relation to the insurer's outstanding liabilities and shall be adequate to its financial needs;[~~.~~] (vii) the commissioner may require the insurer to secure and maintain a deposit held by the commissioner or a bond, as determined by the insurer at the insurer's discretion, in an amount determined by the commissioner not to exceed the value of the agreement in any one year, if the commissioner: (A) determines that the insurer is in a hazardous financial condition under Title 31A, Chapter 27a, Insurer Receivership Act, or a condition that would warrant a delinquency proceeding under Title 31A, Chapter 27a, Insurer Receivership Act; and (B) believes that the insurers' affiliate may be unable to fulfill an agreement with the insurer if the insurer were put into liquidation; (viii) all insurer records and data held by an affiliate: (A) are the insurer's property; (B) are subject to the insurer's control; (C) are identifiable; (D) are segregated or readily capable of segregation, at no additional cost to the insurer, from all other records and data; (E) shall be provided to a receiver, at the insurer's request, including any information, software, licensing agreement, release, waiver, or any other thing required to access the records and data; and (F) may be restricted in use by the affiliate if the affiliate is not operating the insurer's business; and (ix) (A) all funds belonging to the insurer that an affiliate collects or holds are the exclusive property of the insurer and subject to the control of the insurer; and (B) if the insurer is placed into receivership, any right of offset against the funds is subject to Title 31A, Chapter 27a, Insurance Receivership Act.	***Policy change:*** The proposed amendments assure the continuation of essential services provided by affiliates in a holding company system when an insurer becomes financially troubled. The proposed amendments: (a) give the commissioner authority to require deposits or bonds to assure that essential services continue; and (b) in the event of delinquency, bring affiliates under the jurisdiction of a receiver for the purpose of enforcing the agreements to provide essential services.

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Line	**Amendment text**	**Nature of change**
2591	**31A-16-109. Confidentiality of information obtained by commissioner.** (1)(a) Documents, materials, or information obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made under Section 31A-16-107.5, and all information reported or provided to the department under Section 31A-16-105 or 31A-16-108.6, is proprietary, contains trade secrets, and is confidential. (b) Any confidential document, material, or information described in Subsection (1)(a) is not subject to subpoena and may not be made public by the commissioner or any other person without the permission of the insurer, except the confidential document, material, or information may be provided to the insurance departments of other states, without the prior written consent of the insurer to which the confidential document, material, or information pertains. *****	***Policy change:*** The amendments to this section implement a requirement that large insurance holding companies submit to the Insurance Department a Group Capital Calculation (GCC) and the results of a Liquidity Stress Test (LST). The requirement assures that solvency-related information is provided to the Department. Although Utah's current domestic insurers are not sufficiently large to be subject to the requirement, the Department seeks its adoption because the National Association of Insurance Commissioners mandates that the GCC be adopted for accreditation and strongly encourages adoption of the LST. This particular statute requires that the information submitted in connection with the GCC and LST be kept confidential.
2598-2607	(c) The commissioner shall maintain the confidentiality of the following received in accordance with Section 31A-16-105 from an insurance holding company supervised by the Federal Reserve Board or any United States group-wide supervisor: (i) a group capital calculation; (ii) a group capital ratio produced within the group capital calculation; or (iii) group capital information. (d) The commissioner shall maintain the confidentiality of the liquidity stress test results, supporting disclosures, and any liquidity stress test information received in accordance with Section 31A-16-105 from an insurance holding company supervised by the Federal Reserve Board and non-United States group-wide supervisors. *****	
2613	(3) [~~(a)~~] To assist in the performance of the commissioner's duties, the commissioner: [~~(i)~~] (a) may share documents, materials, proprietary and trade secret documents, or other information, including the confidential documents, materials, or information subject to Subsection (1), with the following if the recipient agrees in writing to maintain the confidentiality status of the document, material, or other information, and has verified in writing the legal authority to maintain confidentiality: [~~(A)~~] (i) a state, federal, or international regulatory agency;	
2620-2621	[~~(B)~~] (ii) the [~~National Association of Insurance Commissioners or an NAIC affiliate or 2304 subsidiary; or~~] NAIC; (iii) a third-party consultant designated by the commissioner; or	
	[~~(C)~~] (iv) a state, federal, or international law enforcement authority, including a member of a supervisory college described in Section 31A-16-108.5;	

	[~~(ii)~~] (b) notwithstanding Subsection (1), may only share confidential documents, material, or information reported pursuant to Section 31A-16-105 or 31A-16-108.6 with a commissioner of a state having statutes or regulations substantially similar to Subsection (1) and who has agreed in writing not to disclose the documents, material, or information; [~~(iii)~~] (c) may receive documents, materials, proprietary and trade secret information, or other information, including otherwise confidential documents, materials, or information from: [~~(A)~~] (i) the [~~National Association of Insurance Commissioners~~] NAIC or an NAIC affiliate or subsidiary; or [~~(B)~~] (ii) a regulatory or law enforcement official of a foreign or domestic jurisdiction; [~~(iv)~~] (d) shall maintain as confidential any document, material, or information received under this section with notice or the understanding that it is confidential under the laws of the jurisdiction that is the source of the document, material, or information; and [~~(v)~~] (e) shall enter into written agreements with the [~~National Association of Insurance Commissioners~~] NAIC or a third-party consultant designated by the commissioner governing sharing and use of information provided pursuant to this chapter consistent with this Subsection (3) that shall: [~~(A)~~] (i) specify procedures and protocols regarding the confidentiality and security of information shared with the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries pursuant to this chapter, including procedures and protocols for sharing by the [~~National Association of Insurance Commissioners~~] NAIC with other state, federal, or international regulators; [~~(B)~~] (ii) specify that ownership of information shared with the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries pursuant to this chapter remains with the commissioner and the [~~National Association of Insurance Commissioner's~~] NAIC's use of the information is subject to the direction of the commissioner; [~~(C)~~] (iii) require prompt notice to be given to an insurer whose confidential information in the possession of the [~~National Association of Insurance Commissioners~~] NAIC pursuant to this chapter is subject to a request or subpoena to the [~~National Association of Insurance Commissioners~~] NAIC for disclosure or production; and [~~(D)~~] (iv) require the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the [~~National Association of Insurance Commissioners~~] NAIC and NAIC affiliates and subsidiaries pursuant to this chapter. ***** (6) Documents, materials, or other information in the possession or control of the	

2671-2686	[~~National Association of Insurance Commissioners~~] NAIC pursuant to this chapter are: (a) confidential, not public records, and not open to public inspection; and (b) not subject to Title 63G, Chapter 2, Government Records Access and Management Act. (7) (a) The group capital calculation, including the resulting group capital ratio, and the liquidity stress test, including the liquidity stress test results and supporting disclosures, are: (i) regulatory tools for assessing risk and capital adequacy; and (ii) not a method to rank insurers or insurance holding company systems generally. (b) Except as provided in Subsection (7)(c), an insurer, broker, or other person engaged in the business of insurance may not make, disseminate, or circulate to the public a materially false or misleading statement relating to an insurer's or insurer group's, or a component of an insurer's or insurer group's: (i) group capital calculation; (ii) group capital ratio; (iii) liquidity stress test results; or (iv) liquidity stress test supporting disclosures. (c) If an insurer provides to the commissioner substantial proof that a statement described in Subsection (7)(b) is materially false or misleading, the insurer may publish an announcement in a written publication for the sole purpose of rebutting the materially false or misleading statement.	
Line	**Amendment text**	**Nature of change**
2699-2700	**31A-17-408. Title insurance reserves.** ***** (3) The title insurance company may release the fund in accordance with the standards of the NAIC Accounting Practices and Procedures Manual.	***Codifies practice:*** As written, this statute could be construed to require that the unearned premium reserve fund be held in perpetuity. The National Association of Insurance Commissioners' accounting standards, by contrast, allow for a gradual release of the fund. This amendment assures that the statute is not interpreted contrary to the proper accounting standard.
Line	**Amendment text**	**Nature of change**
4746	[~~**31A-17-519. Small company exemption.**~~ ~~(1) A company that is licensed and doing business in Utah, and whose reserves are computed subject to the requirements of Subsection 31A-17-502(2), in lieu of the reserves required under Sections 31A-17-514 and 31A-17-515, may hold reserves for ordinary life insurance policies issued directly, or assumed, during the current calendar year, based on the mortality tables and interest~~	***Codifies practice:*** The exemption set forth in this statute is also set forth in the NAIC's Valuation Manual with which insurers must comply. The department proposes that the statute

	~~rates defined by the valuation manual for net premium reserves and using the methodology defined in Sections 31A-17-507 through 31A-17-512 as they apply to ordinary life insurance, provided that all of the following conditions have been met:~~ ~~(a) the company has less than $300,000,000 of ordinary life premium;~~ ~~(b) if the company is a member of a group of life insurers, the group has combined ordinary life premiums of less than $600,000,000;~~ ~~(c) the appointed actuary has provided an unqualified opinion on the reserves in accordance with Subsection 31A-17-503(2) for the prior calendar year;~~ ~~(d) any universal life policy with a secondary guarantee issued on or after January 1, 2020, and in force on the company's annual financial statement for the current calendar year-end valuation date, only has secondary guarantees that meets the definition of a non material secondary guarantee as defined in the valuation manual;~~ ~~(e) the company has filed by July 1 of the calendar year for which valuation under Subsection 31A-17-502(2) is required a statement with its domiciliary commissioner certifying that these conditions are met and that the company intends to calculate reserves as described in this section; and~~ ~~(f) the company's domiciliary commissioner has not informed the company in writing before September 1 of the calendar year for which valuation under Subsection 31A-17-502(2) is required that the company must comply with the valuation manual requirements for life insurance reserves.~~ ~~(2) For purposes of Subsections (1)(a) and (b), ordinary life premiums are measured as direct premium plus reinsurance assumed from an unaffiliated company, as reported in the prior calendar year annual statement, excluding premiums for guaranteed issue policies and pre-need life contracts and excluding amounts that represent the transfer of reserves in-force as of the effective date of a reinsurance assumed transaction.~~]	be deleted because it serves no purpose to place the same exemption in the Manual and in the statute.
Lines	**Amendment text**	**Nature of change**
2719-2720	**31A-17-601 Definitions.** As used in this part: ***** (4) "Life or accident and health insurer" means: (a) an insurance company licensed to write life insurance, [~~disability~~]accident and health insurance, or both; or (b) a licensed property casualty insurer writing only disability insurance. *****	***Technical change:*** Several years ago, the Department began using the term "accident and health insurance" for "disability insurance." In making the change, the reference to disability insurance in this statute was overlooked.
Lines	**Amendment text**	**Nature of change**
	31A-21-201. Filing of forms.	

2775 2777- 2778	***** (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; (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 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 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. *****	***Technical change:*** Clarifies that any life or accident and health insurance form must include the name of the insurer, and the state of domicile. While a policy endorsement is considered a 'policy form' the department has had several compliance issues.
Lines	**Amendment text**	**Nature of change**
	31A-21-303. Cancellation, issuance, renewal. ***** (6)(a)(i) Subject to Subsection (6)(b), if the insurer offers or purports to renew the policy, but on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date if the insurer delivered or sent by first-class mail to the policyholder notice of the new terms or rates at least 30 days before the day on which the previous policy expires. (ii) If the insurer did not give the prior notification described in Subsections (6)(a)(i) to the	***Policy Change:*** This statute generally requires a 30-day notice to an insured if a policy will be renewed on less favorable terms or at higher rates. The 30-day notice is not required if: (a) the change is a increase generally applicable to the class of business to

	policyholder, the new terms or rates do not take effect until 30 days after the day on which the insurer delivers or sends by first-class mail the notice, in which case the policyholder may elect to cancel the renewal policy at any time during the 30-day period. (iii) Return premiums or additional premium charges shall be calculated proportionately on the basis that the old rates apply. 2989 (b) <u>Except as provided in Subsection (6)(c),</u> Subsection (6)(a) does not apply if the only change in terms that is adverse to the policyholder is: (i) a rate increase generally applicable to the class of business to which the policy belongs; (ii) a rate increase resulting from a classification change based on the altered nature or extent of the risk insured against; or (iii) a policy form change made to make the form consistent with Utah law. 2996 <u>(c) Subsections (b)(i) and (ii) do not apply to a rate increase of 25 percent or more on a</u> 2997 <u>commercial policy.</u> *****	which the policy belongs; or (b) a rate increase resulting from a classification change based on the altered nature or extent of the risk insured against. The proposed amendment states that the exceptions to the notice requirement do not apply to a rate increase of 25 percent or more on a commercial policy. Representatives of the Insurance Department, the insurance industry, and insurance consumers have agreed to this proposed amendment.
Lines	**Amendment text**	**Nature of change**
	31A-22-305.3. Underinsured motorist coverage. ***** (8) ***** (p) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (8)(m) between the parties unless: 3287 (i) the award is procured by corruption, fraud, or other undue means; <u>or</u> (ii) either party, within 20 days after service of the arbitration award: (A) files a complaint requesting a trial de novo in the district court; and (B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (8)(p)(ii)(A).	***Codifies Practice:*** Clarifies that there are alternative grounds for seeking trial de novo of an arbitration decision. <u>See</u> <u>Halversen, v. Allstate Property and Casualty Ins. Co.</u>, 2021 UT App 59.
Line	**Amendment text**	**Nature of change**
	31A-22-602. Premium rates. (1) Except as provided in Subsection 31A-22-701(4), this section does not apply to group accident and health insurance. (2) The benefits in an accident and health insurance policy shall be reasonable in relation to the premiums charged. 3467 (3) The commissioner shall prohibit the use of [~~a policy offering~~] an accident and health insurance form or rates if the form or rates do not satisfy Subsection (2).	***Technical change:*** This amendment eliminates unnecessary words.

Lines	Amendment text	Nature of change
3476-3568	**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 group 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 benefit 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~~]discontinued or nonrenewed 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 group 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 group 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 group health benefit plan purchased in the small group market. (b) A large employer that, after purchasing a group 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 group health benefit plan purchased in the large group market. (5) A group health benefit plan for a plan sponsor may be discontinued or nonrenewed 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:	***Technical change:*** This amendment clarifies what is considered as an insurer's withdrawal from the group health insurance market. It provides that an insurer that withdraws from offering one line of insurance is not prohibited from offering insurance in another line.

	(i) elects to discontinue offering a particular group health benefit plan delivered or issued for delivery in this state; (ii) provides notice of the discontinuation in writing to each plan sponsor, employee, and dependent of an employee, at least 90 days before the day on which the coverage discontinues; (iii) provides notice of the discontinuation in writing to the commissioner, and at least three working days before the day on which the notice is sent to each affected plan sponsor, employee, and dependent of an employee; (iv) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other group health benefit plans currently being offered by the insurer in the market or, in the case of a large employer, any other group health benefit plans currently being offered in that market; and (v) in exercising the option to discontinue that group 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 eligible for the coverage; or (e) the insurer: (i) elects to discontinue offering all of the insurer's group health benefit plans in: (A) the small employer market; (B) the large employer market; or (C) both the small employer and large employer markets; (ii) provides notice of the discontinuation in writing to each plan sponsor, employee, and dependent of an employee at least 180 days before the day on which the coverage discontinues; (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 day on which the notice is sent to each affected plan sponsor, employee, and dependent of an employee; (iv) discontinues and nonrenews all plans issued or delivered for issuance in the market described in Subsection (5)(e)(i); and (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 whose coverage is discontinued under Subsection (6)(a) may reenroll: (i) 12 months after the 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 discontinues under Subsection (6)(a), the insurer shall notify the eligible employee of the right to reenroll as described in Subsection (6)(b).	

	(d) An eligible 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 group 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 group 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**
3589-3629	**31A-22-618.7. Discontinuance, nonrenewal, and modification 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~~]discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered enrollee; or (b) for coverage made available through an association, if:	***Technical change:*** This amendment clarifies what is considered as an insurer's withdrawal from the individual health insurance market. It provides that an insurer that withdraws from offering one line of insurance is not prohibited from offering insurance in another line.

	(i) the enrollee's membership in the association ceases; and (ii) the coverage is [~~terminated~~]discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered enrollee. (3) An individual health benefit plan may be discontinued or nonrenewed 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: (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 individual 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 day on which the coverage discontinues; (B) provides notice of the discontinuation in writing to the commissioner and, at least three working days before the day on which the notice is sent, to 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 offering all of the insurer's individual 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 day on which the coverage 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 day on which the insurer ends the notice, to each affected enrollee; (C) discontinues and nonrenews all individual 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 individual health benefit plans.	

Lines	Amendment text	Nature of Change
3634-3640	**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 either Subsections 31A-22-618.6(5)(e) [~~and~~]or 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 (b) for a period of five years beginning on the 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, Subsections 31A-22-618.6(5)(e) and 31A-22-618.7(3)(e) apply only to the insurer's operations in that service area. (3) The commissioner may, by rule or order, define the scope of service area.	***Technical change:*** This amendment clarifies what is considered as an insurer's withdrawal from the health benefit plan market. It provides that an insurer that withdraws from offering one line of insurance is not prohibited from offering insurance in another line.
Lines	**Amendment text**	**Nature of change**
3663-3670	**31A-22-627. Coverage of emergency medical services.** ***** (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 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)~~](b) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3). *****	***Technical change:*** Moved definition to 31A-1-301 to assure consistent use of the term.
Lines	**Amendment text**	**Nature of change**
3696-3714	**31A-22-636. Standardized health [~~benefit plan~~]insurance information cards.** ***** (2) In accordance with Subsection (3), an insurer shall use and issue a dental insurance or health benefit plan information card for the insurer's enrollees upon the purchase or renewal of, or enrollment in, a dental insurance or a health benefit plan[~~on or after July 1, 2010~~]. (3) The [~~health benefit plan~~]information card shall include: (a) the covered person's name; (b) the name of the carrier and the carrier network name;	***Codifies practice:*** The amendment provides that dental plan i.d. cards must indicate that the dental plan is state- regulated. This requirement is part of the Utah Health Information Network standards which have been adopted by rule, R590-164-4(6), pursuant to 31A-22-636(4).

	(c) the contact information for the carrier or [~~health benefit~~]plan administrator; (d) general information regarding copayments and deductibles; and (e) an indication of whether the dental insurance or health benefit plan is regulated by the state. (4)(a) The commissioner shall work with the Department of Health, the Health Data Authority, health care providers groups, and with state and national organizations that [~~are developing~~]develop uniform standards for the electronic exchange of health insurance claims or uniform standards for the electronic exchange of clinical health records. (b) [~~When the commissioner determines that the groups described in Subsection (4)(a) have reached a consensus regarding the electronic technology and standards necessary to electronically exchange insurance enrollment and coverage information, the commissioner shall begin the rulemaking process under~~]The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt standardized electronic interchange technology. *****	
Lines	**Amendment text**	**Nature of change**
3721-3738	**31A-22-657. Application of health insurance mandates.** (1) As used in this section: (a) "Cost-sharing requirement" means a copayment, coinsurance, or deductible required by or on behalf of an enrollee in order to receive a benefit under a qualified high-deductible health plan. (b) "Health savings account" means the same as that term is defined in 26 U.S.C. Sec. 223(d)(1). (c) "Qualified high-deductible health plan" means a high-deductible health plan as defined in 26 U.S.C. Sec. 223(c)(2)(A) that is used in conjunction with a health savings account. (d) "Cost-sharing mandate" means a statutory requirement limiting a cost-sharing requirement. (2) (a) Except as provided in Subsection (2)(b), if under federal law, a cost-sharing mandate would result in an enrollee becoming ineligible for a health savings account, the cost-sharing mandate applies only to the enrollee's qualified high-deductible health plan after the enrollee satisfies the enrollee's health plan deductible. (b) Subsection (2)(a) does not apply to an item or service that is preventive care under 26 U.S.C. Sec. 223(c)(2)(C).	***Policy change:*** Exempts individuals with high-deductible health plans that are used with health savings accounts to any cost-sharing insurance mandate until the individual has met the plan's deductible.
Lines	**Amendment text**	**Nature of change**
3740-3756	**31A-22-727. Renewal, cancelation, and modification.** (1) Except as provided in Section 31A-22-618.6, for a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance, an insurer may: (a) decline to renew the policy on the date the policy term expires for a reason stated in the policy; or	***Codifies practice:*** This change clarifies termination and renewability provisions for group accident and health insurance, other than a health benefit plan. The department continuously receives policy forms

	(b) cancel the policy at any time for: (i) nonpayment of a premium when due; (ii) intentional misrepresentation of a material fact in connection with the coverage; (iii) performance of an act or practice that constitutes fraud in connection with the coverage; or (iv) noncompliance with an employer eligibility provision. (2) Except for a modification required by law, an insurer may only modify a policy at renewal. (3) Subsection (2) does not apply to an endorsement by which the insurer: (a) effectuates a request the policyholder made in writing; or (b) exercises a specifically reserved right under the policy.	that include provisions allowing an insurer to terminate a policy at any time for any reason. This change requires the insurer to provide coverage for the risk they accepted at issuance, but allows the insurer to reevaluate the risk at each renewal.
Lines	**Amendment text**	**Nature of change**
3820	**31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.** ***** (5) ***** (b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee or license applicant: (i) is unqualified for a license or line of authority under Section 31A-23a-104, 31A-23a-105, or 31A-23a-107; (ii) violates: (A) an insurance statute; (B) a rule that is valid under Subsection 31A-2-201(3); or (C) an order that is valid under Subsection 31A-2-201(4); (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state; (iv) fails to pay a final judgment rendered against the person [~~in this state~~] within 60 days after the day on which the judgment became final; *****	***Policy change:*** Subsection (5)(b)(iv) states the commissioner may take action against a license of an insurance producer who fails to pay a Utah court judgment within 60 days. The statute is intended to identify insurance producers who are not financially responsible. If not paying a judgement within 60 days is a sign of financial irresponsibility, then it should not matter whether the judgement was entered in a Utah court or another court. The amendment eliminates the requirement that the judgement was entered in a Utah court.
Lines	**Amendment text**	**Nature of change**
3952-3953	**31A-27a-104. Persons covered.** ***** (2) Notwithstanding Sections 31A-1-301 and 31A-27a-102, this chapter does not apply to a person licensed by the insurance commissioner as one or more of the following in this state unless the person engages in the business of insurance as an insurer, is an affiliate as defined in Subsection 31A-1-301(5), or is a person under the control of an affiliate: (a) an insurance agency;	***Policy Change:*** Currently, Utah's Insurer Receivership Act (31A-27) does not apply to affiliates of insolvent insurers. This makes it more difficult for the receiver to obtain funds that rightfully belong to the insurer's estate. Affiliates have been

	(b) an insurance producer; (c) a limited line producer; (d) an insurance consultant; (e) a managing general agent; (f) reinsurance intermediary; (g) an individual title insurance producer or agency title insurance producer; (h) a third party administrator; (i) an insurance adjustor; (j) a life settlement provider; or (k) a life settlement producer. *****	known to illegally siphon funds from the insurer shortly before or after the receiver takes possession. If an insolvent insurer's affiliates were subject to the Receivership Act, it would take less time and money for the receiver to return illegally taken funds to the estate. Example: In a recent case, the insolvent insurer's affiliate pulled $30M of premium funds owed to the insurer and then filed for Chapter 7. The receiver spent many years fighting the affiliate's trustee in bankruptcy court to obtain a return of the funds. If the affiliate had been subject to the Receivership Act, the receiver would have easily obtained the $30M.
Lines	**Amendment text**	**Nature of change**
3975	**31A-27a-111. Actions by and against the receiver.** ***** (2)(a) Subject to Subsection (2)(b), a prior wrongful or negligent action of any present or former receiver, receiver's assistant, receiver's contractor, officer, manager, director, trustee, owner, employee, or agent of the insurer may not be asserted as a defense to a claim by the receiver: (i) under a theory of: (A) estoppel; (B) comparative fault; (C) intervening cause; (D) proximate cause; (E) reliance; or (F) mitigation of damages; or (ii) otherwise. (b) Notwithstanding Subsection (2)(a): (i) the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract; and (ii) a principal under a surety bond or a surety undertaking is entitled to credit against any	***Codifies practice:*** This amendment reflects current law that states that the receiver's actions cannot be used as a defense to improper acts committed by persons involved with the insurer pre-receivership.

	reimbursement obligation to the receiver for the value of any property pledged to secure the reimbursement obligation to the extent that: (A) the receiver has possession or control of the property; or (B) the insurer or its agents misappropriated, including commingling, the property. (c) Evidence of fraud in the inducement is admissible only if it is contained in the records of the insurer. *****	
Lines	**Amendment text**	**Nature of change**
4039	**31A-30-103. Definitions.** ***** (4)(a) "Bona fide employer association" means an association of employers: (i) that meets the requirements of Subsection [~~31A-22-701(2)(b)~~]31A-22-505; (ii) in which the employers of the association, either directly or indirectly, exercise control over the plan; (iii) that is organized: (A) based on a commonality of interest between the employers and their employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits; and (B) to act in the best interests of its employers to provide benefits for the employer's employees and their spouses and dependents, and other benefits relating to employment; and (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121. *****	***Technical change:*** HB54 (2021), Insurance Revisions, association requirements were moved from 31A-22-701(2)(b) to 31A-22-505.
Lines	**Amendment text**	**Nature of change**
4133	**31A-35-404. Minimum financial requirements for bail bond agency license.** *** (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 a verified financial statement for the [~~current~~] bail bond agency's immediately preceding fiscalyear: (i) reviewed by a certified public accountant; and (ii) showing a minimum net worth of: (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. (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. ***	***Technical change:*** The current phrase "verified financial statement for the current year" is ambiguous. It could mean the current calendar year, the current fiscal year or the most recent fiscal or calendar year. The amendment changes the phrase to "the bail bond agency's immediately preceding fiscal year" so that the CPA reviews a verified financial statement for an agency's entire fiscal year.

Lines	Amendment text	Nature of change
4155-4168	**31A-48-102 Definitions.** As used in this chapter: (1) (a) "Drug" means [~~a prescription drug, as defined in Section 58-17b-102.~~] a substance that is: (i) (A) intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans; and (B) recognized in or in a supplement to the official United States Pharmacopoeia, the Homeopathic Pharmacopoeia of the United States, or the official National Formulary; (ii) required by an applicable federal or state law or rule to be dispensed by prescription only; (iii) restricted to administration by practitioners only; (iv) a substance other than food intended to affect the structure or a function of the human body; or (v) intended for use as a component of a substance described in Subsection (1)(a)(i), (ii), (iii), or (iv). (b) "Drug" does not include a dietary supplement.	***Technical change:*** Removes animal drugs from reporting requirements.
Lines	**Amendment text**	**Nature of change**
	31A-48-103 Manufacturer reports -- Insurer report -- Publication by department. (1)(a) A manufacturer of a drug shall, beginning January 1, 2022, report to the department the information described in Subsection (1)(b) no more than 30 days after the day on which an increase to the wholesale acquisition cost of the drug results in an increase to the wholesale acquisition cost of the drug of: (i) greater than 16% over the preceding two calendar years; or (ii) greater than 10% over the preceding calendar year. (b) The manufacturer shall report: (i)(A) the name of the drug; (B) the dosage form of the drug; and (C) the strength of the drug; (ii) whether the drug is a brand name drug or a generic drug; (iii) the effective date of the increase in the wholesale acquisition cost of the drug; (iv) a written description, suitable for public release, of the factors that led to the increase in the wholesale acquisition cost of the drug and the significance of each factor; (v) the manufacturer's aggregate company-wide research and development costs for the most recent year for which final audit data is available; (vi) the name of each of the manufacturer's drugs approved by the United States Food and Drug Administration during the preceding three calendar years; and	

4201-4243	(vii) the names of drugs manufactured by the manufacturer that lost patent exclusivity in the United States during the preceding three calendar years. (c) Subsection (1)(a) applies only to a drug with a wholesale acquisition cost of at least $100 for a 30-day supply before the effective date of the increase in the wholesale acquisition cost of the drug. (d) [~~A manufacturer's obligations under this Subsection (1) are fully satisfied by submission of~~]The quality and types of information and data that a manufacturer submits under this Subsection (1) must be consistent with the quality and types of information and data that the manufacturer includes in the manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K or any other public disclosure. (e) The department shall consult with representatives of manufacturers to establish a single, standardized format for reporting information under this section that minimizes the administrative burden of reporting for manufacturers and the state. [~~(f) Information provided to the department under Subsection (1)(b) may not be released in a manner that:~~ ~~(i) would allow for the identification of an individual drug, therapeutic class of drugs, or manufacturer; or~~ ~~(ii) is likely to compromise the financial, competitive, or proprietary nature of the information.~~] (2) On or before August 1, 2021, and on or before August 1 of each year thereafter, an insurer shall report to the department in aggregate the following information for the preceding calendar year for health benefit plans offered by the insurer: (a) for the 25 drugs for which spending by the insurer was the greatest, after adjusting for rebates: (i) the name of the drug; (ii) the dosage form of the drug; and (iii) the strength of the drug; (b) the percentage increase over the previous year in net spending for all drugs, after adjusting for rebates;[~~and~~] (c) the percentage of the increase in premiums over the previous year attributable to all drugs; and (d) the percentage of the increase in premiums over the previous year attributable to specialty drugs. (3) The department shall publish on the department's website: (a) no later than 60 days after receiving the information, information reported to the department under Subsection (1); and (b) no later than December 1 of each year, information reported to the department under Subsection (2).	***Policy change:*** Changes that the SEC 10-K form does not satisfy all reporting requirements. Proposed language is used in other states.

	(4)(a) The department may not release or publish information under [~~Subection (3)(b)~~]this section in a manner that: (i) allows the identity of an insurer to be determined[~~.~~]; (ii) allows for the identification of an individual drug, therapeutic class of drugs, or a manufacturer; or (iii) is likely to compromise the financial, competitive, or proprietary nature of the information. (b) The commissioner shall classify each records submitted under this section as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act. (5) The department shall make rules, as necessary, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to promote comparability of information reported to the department under this chapter.	***Technical change:*** Clarifies all records submitted are protected records.
Lines	**Amendment text**	**Nature of change**
4666	**63G-2-305. Protected records.** ***** (79) a record submitted to the Insurance Department under Subsection 31A-48-103[~~(1)(b)~~]; *****	***Technical change:*** See changes to 31A-48-103.
Lines	**Amendment text**	**Nature of change**
4700	**76-6-521. Fraudulent insurance act.** (1) A person commits a fraudulent insurance act if that person with intent to deceive or defraud: *****	***Technical change:*** This amendment brings the Criminal Code in line with the Insurance Code which states at 31A-31-103: "(1) A person commits a fraudulent insurance act if that person with intent to *deceive or* defraud. . . ."