Summary of HB 0024S1, Insurance Related Amendments (1/28/14)
Representative Jim Dunnigan – Chief Sponsor
Senate Sponsor – Senator Curtis Bramble

	Technical change: Formatting, numbering, word order, or language changes; no change in intent or practice; **Codifying existing practice:** New or changed language, no change in practice; **Policy Change:** New language, new practice.	
Lines	**Cite Change**	**Effect / Benefits**
	31A-1-301 – Definitions	
658	(87) "Insurance adjuster" means a person who directs or handles the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.	**Technical change:** (87) adds clarifying language to the definition of "insurance adjuster"
828	(107) "Limited lines authority" includes [~~: (a)~~] the lines of insurance listed in Subsection (106) [~~; and (b) a customer service representative~~].	**Technical change:** (107) deletes reference to "customer service representative", a license type that was removed in 2012.
1077-79	(145) "Rebate" means to refund or return a portion of the premium from the premium paid, commission paid, or consultant feed paid, directly or indirectly, on the sale or renewal of an insurance policy.	**Codifying existing practice:** (145) adds new definition of "rebating", a term currently used in statute but not defined.
1167-1173	[~~(158)~~] (159) "Small employer [~~,~~]" means in connection with a health benefit plan [~~, means an employer who,~~] and with respect to a calendar year and to a plan year, an employer who: (a) employed an average of at least [~~two employees~~] one employee but not more than an average of 50 eligible employees on [~~each~~] business [~~day~~] days during the preceding calendar year; and (b) employs at least [~~two employees~~] one employee on the first day of the plan year.	**Codifying existing practice:** (159) The Affordable Care Act (ACA) requires the definition of small employer to include an employer who employees at least one employee for purposes of health insurance.
	31A-2-104. Other employees – Insurance fraud investigators.	
1295-99	(2) An insurance fraud investigator employed pursuant to Subsection (1) may as approved by the commissioner: (a) be designated a [~~special function~~] law enforcement officer, as defined in Section [~~53-13-105, by the commissioner, but is not~~] 53-13-103; and (b) be eligible for retirement benefits under the Public Safety Employee's Retirement System.	**Policy change:** Grants authority to the commissioner to Change the status of the 11 fraud investigators from special function law enforcement officers to full law enforcement officers. If approved by the commissioner, the change enhances the fraud investigators' ability to react as law enforcement, and strengthens ability to recruit and retain qualified investigators. The change in retirement system

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		status to law enforcement retirement, can be supported by the Fraud Division's Budget.
	31A-3-103. Fees.	
1320, 1334 and 1338-1341	(4)(a) [~~Beginning July 1, 2011, there~~] There is created in the General Fund a restricted account known as the "Insurance Department Restricted Account." (b) Except as provided in Subsection (4)(c), the Insurance Department Restricted Account shall consist of: (i) fees authorized by this section; and (ii) other money received by the department, including: (A) reimbursements for examination costs incurred by the department; and (B) forfeitures collected under this title. . . . (e)(i) At the end of each fiscal year until June 30, 2015, the director of the Division of Finance shall transfer into the General Fund any money deposited into the Insurance Department Restricted Account under Subsection (4)(b) that exceeds the legislative appropriates from the Insurance Department Restricted Account for that year. (ii) Beginning with fiscal year 2015-2016, an appropriation of the Insurance Department Restricted Account is nonlapsing, except that at the end of each fiscal year, money received by the commissioner in excess of $8,500,000 shall be treated as free revenue in the General Fund.	**Policy change:** Beginning in FY 2016, captures in the Insurance Department Restricted Account, fees and forfeitures paid to the Department up to a capped amount of $8.5 million. Fees and forfeitures collected by the Department in excess of that amount are transferred to the General Fund.
	31A-3-304. (Superseded 07/01/15). Annual fees – Other taxes or fees prohibited – Captive Insurance Restricted Account.	
1367	(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June [~~20~~]1 of each year.	**Policy change:** Moves forward by 20 days to June 1st, the annual fee paid by captive insurers to alleviate administrative and accounting issues related to the current proximity to FY end on 7/1.
	31A-3-304. (Effective 07/01/15). Annual fees – Other taxes or fees prohibited – Captive Insurance Restricted Account.	
1409	(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June [~~20~~]1 of each year.	**Policy change:** Moves forward by 20 days to June 1st, the annual fee paid by captive insurers to alleviate administrative and accounting issues related to the current proximity to FY end on 7/1.
	31A-4-102. Qualified insurers.	
1428-1442	(1) A person may not conduct an insurance business in Utah in person, through an agent, through a broker, through the mail, or through another method of communication, except: (a) an insurer: (i) authorized to do business in Utah under [~~Chapter 5, 7, 8, 9, 10, 11, 13, or 14; and~~]: (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations; (B) Chapter 7, Nonprofit Health Service Insurance Corporations;	**Codifying existing practice:** Adds captive and special purpose financial captive insurers *(sub sections I and J)* to the definition of a "qualified insurer", which makes applicable to those captive insurer

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	(C) Chapter 8, Health Maintenance Organizations and Limited Health Plans; (D) Chapter 9, Health Discount Program Consumer Protection Act; (E) Chapter 10, Annuities; (F) Chapter 11, Motor Clubs; (G) Chapter 13, Employee Welfare Funds and Plans; (H) Chapter 14, Foreign Insurers; (I) Chapter 37, Captive Insurance Companies Act; or (J) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and	types general insurance company laws (a previous oversight).
	31A-4-115. Plan of orderly withdrawal.	
1469- 1473	(2) An insurer's plan of orderly withdrawal shall: (a) indicate the date the insurer intends to begin and complete its withdrawal plan; and (b) include provisions for: (i) meeting the insurer's contractual obligations; (ii) providing services to its Utah policyholders and claimants; (iii) meeting ~~[any]~~ applicable statutory obligations; and (iv)[~~(A)~~] the payment of a withdrawal fee of $50,000 to the [~~Utah Comprehensive Health Insurance Pool if:~~ ~~(I) the insurer is an accident and health insurer; and~~ ~~(II) the insurer's line of business is not assumed or placed with another insurer approved by the commissioner; or~~ ~~(B) the payment of a withdrawal fee of $50,000~~]to the department if[~~:~~ ~~(I) the insurer is not an accident and health insurer; and~~ ~~(II)~~] the insurer's line of business is not assumed or placed with another insurer approved by the commissioner. . . .	**Policy change:** the Utah Comprehensive Health Insurance Pool (HIP) is closing enrollment as of 1/1/2014 as a result of the ACA. The change requires a health insurer to pay the withdrawal fee to the department, as with all other insurers, rather than HIPUtah.
1494- 1498	(6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer: (a) withdraws from writing insurance in this state without receiving the commissioner's approval of a plan of orderly withdrawal; or (b) reduces its total annual premium volume by 75% or more in any year without [~~having submitted a plan or receiving the commissioner's approval~~] receiving the commissioner's approval of a plan of orderly withdrawal. (7) An insurer that withdraws from writing all lines of insurance in this state may not resume writing insurance in this state for five years unless[~~: (a)~~] the commissioner finds that the prohibition should be waived because the waiver is: [~~(i)~~] (a) in the public interest to promote competition; or [~~(ii)~~] (b) to resolve inequity in the marketplace[; and].	**Codifying existing practice:** clarifies that in order to avoid paying the withdrawal fee penalty an insurer must not only submit a plan of orderly withdrawal, the plan must also get the commissioner's approval.
1504	[~~(b) the insurer complies with Subsection 31A-30-108(5), if applicable.~~]	**Policy change:** deletes reference to HIPAA alternative mechanism statute that is being deleted in this bill in conformity with the ACA.

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	31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit plans.	
1514-1519	(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed: (a) for a network plan, if[: (i)] there is no longer any enrollee under the group health plan who lives, resides, or works in: ~~[(A)]~~ (i) the service area of the insurer; or ~~[(B)]~~ (ii) the area for which the insurer is authorized to do business; [and] or ~~[(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or]~~	**Codification of existing practice:** Under the ACA, policies are issued on a guaranteed basis.
	31A-16-103. Acquisition of control of or merger with domestic insurer.	
1921-1923	(b) Information obtained by the department from the review of criminal history records received under Subsection (3)(a) shall be used by the department for the purpose of: (i) verifying the information in Subsection (2)(a)(i); (ii) determining the integrity of persons who would control the operation of an insurer; and (iii) preventing persons who violate 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~] from engaging in the business of insurance in the state.	**Technical change:** Corrects reference to U.S. Code section.
	31A-17-607. Hearings.	
1920-23	(1) (a) Following receipt of a notice described in Subsection (2), the insurer or health organization shall have the right to a confidential departmental hearing at which the insurer or health organization may challenge [~~any~~] a determination or action by the commissioner. (b) The insurer or health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under [~~Subsections 31A-17-604(1), (2), and (3)~~] Subsection (2).	**Technical change:** Promotes clarity by removing reference to unnecessary code citations related to a defined regulatory action level event and due process right to a hearing.
	31A-22-428. Interest payable on life insurance proceeds.	
1948-1959	(1) For a life insurance policy delivered or issued for delivery in this state on or after May 5, 2008, the insurer shall pay interest on the death proceeds payable upon the death of the insured. (2) (a) Except as provided in Subsection (4), for the period beginning on the date of death and ending the day before the day described in Subsection (3)(b), interest under Subsection (1) shall accrue at a rate no less than the greater of: (i) the rate applicable to policy funds left on deposit; ~~[or]~~ and (ii) [~~if there is no rate described in Subsection (2)(a)(i), at~~] the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve. (b) If there is no rate applicable to policy funds on deposit as stated in Subsection (2)(a)(i), then the Two Year Treasury Constant Maturity Rates as published by the Federal Reserve applies. ~~[(b)]~~ (c) The rate described in Subsection (2)(a) or (b) is the rate in effect on the day on which the death occurs. ~~[(c)]~~ (d) Interest is payable until the day on which the claim is paid.	**Policy change:** Sets as a floor or minimum the Two Year Treasury Constant Maturity Rate for purposes of calculating a death benefit under a life policy if the policy is silent as to the applicable rate.
	31A-22-617. Preferred provider contract provision.	
1984-1991	(1) Subject to restrictions under this section, [~~any~~] an insurer or third party administrator may enter into contracts with health care providers as defined in Section 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer. (a) (i) A health care provider contract may require the health care provider to accept the specified payment in this Subsection (1) as payment in full, relinquishing the right to collect additional amounts from the insured person.	**Technical change:** The drafter made several non-substantive changes.

(ii) In [~~any~~] a dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer's written payment policies in effect at the time services were rendered.

(iii) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(v) If an insurer permits another entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks of participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network.

(b) The insurance contract may reward the insured for selection of preferred health care providers by:

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;

(iv) other copayments; or

(v) any other reasonable manner.

(c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(1)(f):

(i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

(A) require the health care provider to continue to provide health care services under the contract until the earlier of:

(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);

(ii) the provider is required to:

(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);

(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain [~~the language required by~~] requirements described in Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

(A) sums owed by the insolvent managed care organization; or

(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

(iv) the following may not bill or maintain any action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):

(A) a provider;

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2113-2120	(B) an agent; (C) a trustee; or (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and (v) notwithstanding Subsection (1)(c)(i): (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and (B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of: (I) a petition for rehabilitation; or (II) a petition for liquidation. ~~[(9) Except as provided in Subsection 31A-22-618.5(3)(a), insurers are subject to Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.]~~ ~~[~~(10)~~]~~ (9) Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan. [~~(11)~~](10) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625. [~~(12)~~](11) Notwithstanding [~~the provisions of~~] Subsection (1), Subsection (7)(b), and Section 31A-22-618, an insurer or third party administrator is not required to, but may, enter into [~~contracts~~] a contract with a licensed athletic [~~trainers~~] trainer, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.	**Technical change:** Due to proposed changes to 31A-22-618.5 this section is no longer required.
	31A-22-618.5. Health benefit plan offerings.	
1251	(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans: (a) [~~notwithstanding Subsection 31A-22-617(9),~~] may offer a health benefit plan that is not subject to [Section 31A-22-618; (b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627; and (c) is not subject to]coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.	**Codifying existing practice:** Effective January 1, 2014, the ACA prohibits an insurer from discriminating against health care professionals for health insurers, including health maintenance organizations.
	31A-22-625. Catastrophic coverage of mental health conditions.	
2205, 2227-2230 and 2261-2271	(2) (a) At the time of purchase and renewal on or before January 1, 2014, an insure shall offer to a small employer that it insures or seeks to insure a choice between: (i) (A) catastrophic mental health coverage; or (B) federally qualified mental health coverage as described in Subsection (3); and (ii) 50/50 mental health coverage. (b) In addition to complying with Subsection (2)(a), an insurer may offer to provide: (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or (ii) coverage that excludes benefits for mental health conditions. (c) A small employer may, at its option, regardless of the employer's previous coverage for mental health conditions,	**Codifying existing practice:** Effective January 1, 2014, the ACA requires health care insurance policies to comply with the parity requirements of federal Mental Health and Substance Abuse Parity Act.

choose either:

(i) coverage offered under Subsection (2)(a)(i);

(ii) 50/50 mental health coverage; or

(iii) coverage offered under Subsection (2)(b).

(d) An insurer is exempt from the 30% index rating restriction in Section 31A-30-106.1 and, for the first year only that the employer chooses coverage that meets or exceeds catastrophic mental health coverage, the 15% annual adjustment restriction in Section 31A-30-106.1, for [~~any~~] a small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3) (a) An insurer shall offer a large employer mental health and substance use disorder benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.

(b) An insurer shall provide in an individual or small employer health benefit plan, mental health and substance use disorder benefits in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.

(4) (a) [An] For a policy issued or renewed before January 1, 2014, an insurer may provide catastrophic mental health coverage to a small employer through a managed care organization or system in a manner consistent with Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the insurance policy uses a managed care organization or system for the treatment of physical health conditions.

(b) (i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.

(iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition shall be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility:

(A) licensed or otherwise authorized to provide mental health services pursuant to:

(I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and

(B) that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may prohibit an insurance policy that provides mental health coverage in a manner that is inconsistent with this section.

(6) The commissioner [shall: (a)] may adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this section[; and].

~~[(b) provide general figures on the percentage of insurance policies that include:]~~

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	~~[(i) no mental health coverage;]~~ ~~[(ii) 50/50 mental health coverage;]~~ ~~[(iii) catastrophic mental health coverage; and~~] ~~[(iv) coverage that exceeds the minimum requirements of this section.]~~ ~~[(7) This section may not be construed as discouraging or otherwise preventing an insurer from providing mental health coverage in connection with an individual insurance policy.]~~	
	31A-22-635. Uniform application – Uniform waiver of coverage – Information on Health Insurance Exchange.	
2281-2326	(1) For purposes of this section, "insurer": (a) is defined in Subsection 31A-22-634(1); and (b) includes the state employee's risk pool under Section 49-20-202. (2) (a) Insurers offering a health benefit plan to an individual or small employer shall use a uniform application form. (b) The uniform application form: (i) [~~except for cancer and transplants~~], may not include questions about an applicant's health history~~[prior to the previous five years]~~; and (ii) shall be shortened and simplified in accordance with rules adopted by the commissioner. (c) Insurers offering a health benefit plan to a small employer shall use a uniform waiver of coverage form, which may not include health status related questions [~~other than pregnancy~~], and is limited to: (i) information that identifies the employee; (ii) proof of the employee's insurance coverage; and (iii) a statement that the employee declines coverage with a particular employer group. (3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may, if the combination or modification is approved by the commissioner, be combined or modified to facilitate a more efficient and consumer friendly experience for: (a) enrollees using the Health Insurance Exchange; or (b) insurers using electronic applications. (4) The uniform application form, and uniform waiver form, shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. (5) (a) An insurer who offers a health benefit plan [~~in either the group or individual market~~] on the Health Insurance Exchange created in Section 63M-1-2504, shall: (i) accept and process an electronic submission of the uniform application or uniform waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to Section 63M-1-2506; (ii) if requested, provide the applicant with a copy of the completed application either by mail or electronically; (iii) post all health benefit plans offered by the insurer in the defined contribution arrangement market on the Health Insurance Exchange; and (iv) post the information required by Subsection (6) on the Health Insurance Exchange for every health benefit plan the insurer offers on the Health Insurance Exchange. (b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans on the Health Insurance Exchange may not directly or indirectly offer products on the Health Insurance Exchange that are not health benefit plans. (c) Notwithstanding Subsection (5)(b):	**Codifying existing practice:** Effective January 1, 2014, the ACA prohibits insurers from collecting health information and rating policies based on health status.

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	(i) an insurer may offer a health savings account on the Health Insurance Exchange; and (ii) an insurer may offer dental [and vision] plans on the Health Insurance Exchange. if: ~~[(A) the department determines, after study and consultation with the Health System Reform Task Force, that the department is able to establish standards for dental and vision policies offered on the Health Insurance Exchange, and the department determines whether a risk adjuster mechanism is necessary for a defined contribution vision and dental plan market on the Health Insurance Exchange; and~~] ~~[(B)]~~ (iii) the department ~~[, in accordance with recommendations from the Health System Reform Task Force, adopts]~~ may make administrative rules to regulate the offer of dental [~~and vision~~] plans on the Health Insurance Exchange.	**Technical change:** The Insurance Department and Health System Reform Task Force met during the summer of 2013 and completed the referenced study.
	31A-22-721. A Health benefit plan for a plan sponsor – Discontinuance and nonrenewal	
2358-2361	2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed: (a) for a network plan, if~~[: (i)]~~ there is no longer any enrollee under the group health plan who lives, resides, or works in: ~~[(A)]~~ (i) the service area of the insurer; or ~~[(B)]~~ (ii) the area for which the insurer is authorized to do business; [~~and~~] or ~~[(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or]~~	**Codifying existing practice:** Deletes reference to code section proposed to be removed by this bill due to the ACA guarantee issue requirements.
	31A-23a-102. Definitions.	
2545-46	(10) "Resident" is as defined by rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.	**Policy change:** requires the commissioner to define the term "resident" by rule as the term relates to producer licensing to address cross-border enforcement issues.
	31A-23a-104. Application for individual license – Application for agency license	
2622	(5) (a) Subject to Subsection (5)(b), to obtain or renew an agency license, a person shall: (i) file an application for an initial or renewal agency license with the commissioner on forms and in a manner the commissioner prescribes; and (ii) pay a license fee that is not refunded if the application: (A) is denied; or (B) is incomplete when filed and is never completed by the applicant. (b) An application described in Subsection (5)(a) shall provide: (i) information about the applicant's identity; (ii) the applicant's federal employer identification number; (iii) the designated responsible licensed [~~producer~~] individual; (iv) the identity of the owners, partners, officers, and directors; (v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23a-105 or 31A-23a-111; and (vi) any other information the commissioner reasonably requires.	**Technical change:** deleting the term "producer" and inserting "individual" is necessary to be consistent with language in 31A-23a-302.5, which requires an "individual" be designated by an agency.

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	31A-23a-105. General requirements for individual and agency license issuance and renewal.	
2656	(1) (a) The commissioner shall issue or renew a license to a person described in subsection (1)(b) to act as: (i) a producer; (ii) a surplus lines producer; (iii) a limited line producer; (iv) a consultant; (v) a managing general agent; or (vi) a reinsurance intermediary. (b) The commissioner shall issue or renew a license under Subsection (1)(a) to a person who, as to the license type and line of authority classification applied for under Section 31A-23a-106: (i) satisfies the application requirements under Section 31A-23a-104; (ii) satisfies the character requirements under Section 31A-23a-107; (iii) satisfies any applicable continuing education requirements under Section 31A-23a-202; (iv) satisfies any applicable examination requirements under Section 31A-23a-108; (v) satisfies any applicable training period requirements under Section 31A-23a-203; (vi) if an applicant for a resident individual producer license, certifies that, to the extent applicable, the applicant: (A) is in compliance with Section 31A-23a-203.5; and (B) will maintain compliance with Section 31A-23a-203.5 during the period for which the license is issued or renewed; (vii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23a-111; (viii) if a nonresident: (A) complies with Section 31A-23a-109; and (B) holds an active similar license in that person's home state[~~-of residence~~]; (ix) if an applicant for an individual title insurance producer or agency title insurance producer license, satisfies the requirements of Section 31A-23a-204; (x) if an applicant for a license to act as a life settlement provider or life settlement producer, satisfies the requirements of Section 31A-23a-117; and (xi) pays the applicable fees under Section 31A-3-103.	**Policy change:** changes requirement from state of "residence" to "home" state for producer licensing to allow for a designated home state to be used when a producer's home state does not issues a particular license or line of authority (like adjusters). This is consistent with uniform model language.
	31A-23a-108. Examination requirements.	
2770-71 and	(1) (a) The commissioner may require applicants for any particular license type under Section 31A-23a-106 to pass a line of authority examination as a requirement for a license, except that an examination may not be required of applicants for: (i) licenses under Subsection 31A-23a-106(2)(c); or (ii) other limited line license lines of authority recognized by the commissioner or the Title and Escrow Commission by rule as provided in Subsection 31A-23a-106 (3). (b) The examination described in Subsection (1)(a): (i) shall reasonably relate to the line of authority for which it is prescribed; and (ii) may be administered by the commissioner or as otherwise specified by rule. (2) The commissioner shall waive the requirement of an examination for a nonresident applicant who: (a) applies for an insurance producer license in this state within 90 days of establishing legal residence in this state; (b) has been licensed for the same line of authority in another state; and	**Technical change:** These changes clarify that the requirement of applying for licensure within 90 days of establishing legal residence in Utah is a not a stand-alone requirement to be exempt from exam requirements, but is in addition to other requirements new residents must meet to qualify for an exemption.

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	(c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant applies for an insurance producer license in this state; or (ii) if the application is received within 90 days of the cancellation of the applicant's previous license: (A) the prior state certifies that at the time of cancellation, the applicant was in good standing in that state; or (B) the state's producer database records maintained by the National Association of Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority requested.	The drafter also made other technical updates that are non-substantive.
2783-2788	[~~(3) A nonresident producer licensee who moves to this state and applies for a resident license within 90 days of establishing legal residence in this state shall be exempt from any line of authority examination that the producer was authorized on the producer's nonresident producer license, except where the commissioner determines otherwise by rule.~~] [~~(4)~~] (3) This section's requirement may only be applied to [~~applicants who are natural persons~~] an applicant who is a natural person.	
	31A-23a-112. Probation – Grounds for revocation.	
2790-2800 and 2812-14	(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows: (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under Section 31A-23a-111; or (b) at the issuance or renewal of a [~~new~~] license: (i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or (ii) with: (A) a response to background information questions on a new or renewal license application [~~indicating that:~~] or information received from a background check conducted in connection with a new or renewal license application that indicates: . . . (2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]. (3) The probation order shall state the conditions for retention of the license, which shall be reasonable. (4) Any violation of the probation is grounds for revocation pursuant to any proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.	**Codification of existing practice:** currently the Insurance Code only allows the commissioner to place a new applicant on probation if background check information so warrants. The new language authorizes the commissioner to place a licensee on probation upon *renewal*, in addition to the existing authority to place a licensee on probation upon *new* application. **Technical change:** Corrects reference to U.S. Code section.
	31A-23a-113. License lapse and voluntary surrender.	
2828	(1) (a) A license issued under this chapter 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 [~~resident~~] licensee's home state if the licensee is a nonresident licensee. (b) (i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):	**Technical change:** changes requirement from state of "residence" to "home" state for producer licensing to allow for a designated home state to be used when a producer's home state does not issues a particular license or line of authority (like adjusters).

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2849-2852	(A) military service; (B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or . . . (2) If a license 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 is voluntarily surrendered; and (b) no later than one year after the day on which the license is voluntarily surrendered. [~~(3) A voluntarily surrendered license that is reinstated during the license period set forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the license complies with any applicable continuing education requirements for the period during which the license was voluntarily surrendered.~~]	**Technical change:** Deletes subsection that addresses a situation which is not possible. The deleted section requires a licensee that voluntarily surrendered a license to comply with CE requirements.
	31A-23a-202. Continuing education requirements	
	(3) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (3). . . . (d) (i) A licensee is exempt from continuing education requirements under this section if: (A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;	**Policy change:** Moves forward the exemption date from continuing education requirements, based on when an individual was first licensed by the Department, from April 1, 1978 to December 31, 1982.
	31A-23a-203. Training period requirements.	
2950	(1) A producer is eligible to become a surplus lines producer only if the producer: (a) has passed the applicable surplus lines producer examination; (b) has been a producer with property [~~and~~] or casualty or both lines of authority for at least three years during the four years immediately preceding the date of application; and (c) has paid the applicable fee under Section 31A-3-103. (2) A person is eligible to become a consultant only if the person has acted in a capacity that would provide the person with preparation to act as an insurance consultant for a period aggregating not less than three years during the four years immediately preceding the date of application. (3) (a) A resident producer with an accident and health line of authority may only sell long-term care insurance if the producer: (i) initially completes a minimum of three hours of long-term care training before selling long-term care coverage; and (ii) after completing the training required by Subsection (3)(a)(i), completes a minimum of three hours of long-term care training during each subsequent two-year licensing period. (b) A course taken to satisfy a long-term care training requirement may be used toward satisfying a producer continuing education requirement. (c) Long-term care training is not a continuing education requirement to renew a producer license. (d) An insurer that issues long-term care insurance shall demonstrate to the commissioner, upon request, that a producer who is appointed by the insurer and who sells long-term care insurance coverage is in compliance with this Subsection (3). (4) The training periods required under this section apply only to an individual applying for a license under this chapter.	**Technical change:** This change is needed in order to be consistent with the lines of authority offered under the surplus lines producer type license in 31A-23a-106(2)(b). To obtain a surplus lines license the producer is required to have EITHER a property OR casualty line of authority or both – they can have one but not the other – this change addresses that technical inconsistency.

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	31A-23a-402.5. Inducements.	
3067-68	(4) Items not prohibited by Subsection (1) include a producer, consultant, or other licensee, or an officer or employee of a licensee, either directly or through a third party: . . . (q) assisting with a summary plan description including providing a summary plan description wrap-around;	**Technical change:** clarifies that included with the ability to assist clients with a summary plan description assisting with a summary plan description wrap-around (single document that may include multiple employee benefit programs, some of which may not be insurance related) is also allowed.
3141-42	(7) (a) A de minimis gift or meal not to exceed $25 for each individual receiving the gift or meal is presumed to be a social courtesy not conditioned on a quote or purchase of a particular insurance product for purposes of Subsection (4)(a). (b) Notwithstanding Subsection (4)(a), a de minimis gift or meal not to exceed $10 may be conditioned on receipt of a quote of a particular insurance product [~~if the de minimis gift or meal is provided by the insurer and not by a producer or consultant.~~]	**Policy change:** deletes language which requires that a gift, conditioned on receipt of a quote, can only be provided by an insurer, not a producer/agent.
	31A-23b-102. Definitions.	
3162-3190	(3) (a) "Exchange" means an online marketplace[~~: (i) for an individual to purchase qualified health plan; and (ii)~~] that is certified by the United States Department of Health and Human Services as either a state-based small employer exchange or a federally individual facilitated exchange under PPACA. (b) [~~(i)~~] "Exchange" does not include[~~: (A)~~] an online marketplace for the purchase of health insurance if the online marketplace is not a certified exchange [~~under PPACA; or~~] in accordance with Subsection (3)(a). [~~(B) except as provided in Subsection (3)(b)(ii), an online marketplace for small employers that is certified as a PPACA compliant SHOP exchange.~~] [~~(ii) For purposes of this chapter, exchange does include a small employer SHOP exchange described under Subsection 3)(b)(i)(B) if:~~] [~~(A) federal regulations under PPACA require a small employer exchange to allow navigators to assist small employers and their employees with selection of qualified health plans on a small employer exchange; and~~] [~~(B) the state has not entered into an agreement with the United States Department of Health and Human Services that permits the state to limit the scope of practice of navigators to only the individual PPACA exchange.~~] (4) "Navigator": (a) means a person who facilitates enrollment in an exchange by offering to assist, or who advertises any services to assist, with: (i) the selection of and enrollment in a qualified health plan or a public program offered on an exchange; or (ii) applying for premium subsidies through an exchange; and (b) includes a person who is an in-person assister or [~~an~~] a certified application assister as described in[~~: (i)~~] federal regulations or guidance issued under PPACA[~~; and~~]. [~~(ii) the state exchange blueprint published by the Center for Consumer Information and Insurance Oversight within the~~	**Technical change:** updates the definition of the term "exchange" and "navigator" consistent with guidance in the evolution of the ACA roll-out.

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3194-95	~~Centers for Medicare and Medicaid Services in the United States Department of Health and Human Services.]~~ . . . (7) "Resident" is as defined by rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.	**Policy change:** requires the commissioner to promulgate a rule to define the term "resident".
	31A-23b-202. Qualifications for a license.	
3212	(1) (a) The commissioner shall issue or renew a license to a person to act as a navigator if the person: (i) satisfies the: (A) application requirements under Section 31A-23b-203; (B) character requirements under Section 31A-23b-204; (C) examination and training requirements under Section 31A-23b-205; and (D) continuing education requirements under Section 31A-23b-206; (ii) certifies that, to the extent applicable, the applicant: (A) is in compliance with the surety bond requirements of Section 31A-23b-207; and (B) will maintain compliance with Section 31A-23b-207 during the period for which the license is issued or renewed; and (iii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23b-401. (b) A license issued under this chapter is valid for [~~two years~~] one year.	**Policy change:** The training and certification required by the U.S. Department for Health & Human Services (HHS) for navigators is an annual process. The changes proposed are consistent with the education and certification requirements of HHS.
	31A-23b-205. Examination and training requirements.	
3290-3298	(1) The commissioner may require [~~applicants~~] an applicant for a license to pass an examination and complete a training program as a requirement for a license. (2) The examination described in Subsection (1) shall reasonably relate to: (a) the duties and functions of a navigator; (b) requirements for navigators as established by federal regulation under PPACA; and (c) other requirements that may be established by the commissioner by administrative rule. (3) The examination may be administered by the commissioner or as otherwise specified by administrative rule. (4) The training required by Subsection (1) shall be approved by the commissioner and shall include: (a) accident and health insurance plans; (b) qualifications for and enrollment in public programs; (c) qualifications for and enrollment in premium subsidies; (d) cultural and linguistic competence; (e) conflict of interest standards; (f) exchange functions; and (g) other requirements that may be adopted by the commissioner by administrative rule. (5) The training required by Subsection (1) shall consist of: (a) at least 21 hours of training prior to obtaining a license; (b) at least 1 of the 21 credit hours described in Subsection (5)(a) be training on defined contribution arrangement and the small employer SHOP exchange; and (c) the navigator training and certification program developed by the Centers for Medicare and Medicaid Services. [~~(5)~~](6) This section applies only to[~~applicants who are natural persons~~] an applicant who is a natural person.	**Policy change:** The changes proposed to be consistent with the education and certification requirements of HHS; and require navigators to attend a one hour course on Avenue H.

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	31A-23b-206. Continuing education requirements.	
3314-3332 and 3348	(3) (a) Continuing education requirements shall require: (i) that a licensee complete [~~24~~] 12 credit hours of continuing education for every [~~two-year~~] one-year licensing period; (ii) that [~~3~~] at least 2 of the [~~24~~] 12 credit hours described in Subsection (3)(a)(i) be ethics courses; [~~and~~] [~~(iii) that the licensee complete at least half of the required hours through classroom hours of insurance and exchange related instruction.~~] (iii) that at least 1 of the 12 credit hours described in Subsection (3)(a)(i) be defined contribution course that includes training on use of the Health Insurance Exchange; and (iv) that a licensee complete the annual navigator training and certification program developed by the Centers for Medicare and Medicaid Services. (b) An hour of continuing education in accordance with Subsection (3)(a)(i) may be obtained through: (i) classroom attendance; (ii) home study; (iii) watching a video recording; or [~~(iv) experience credit; or~~] [~~(v)~~] (iv) another method approved by rule. (c) A licensee may obtain continuing education hours at any time during the [~~two-year~~] one-year license period.	**Policy change:** For navigator licensees, changes the number of required continuing education hours from 24 in a two year period to 12 hours each year, consistent with the annual training and certification required by HHS for navigators. Also requires 1 hour training on the Health Insurance Exchange and the annual CMS training.
3334-3336	(d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall, by rule[~~:~~ ~~(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(b); and (ii)~~] authorize one or more continuing education providers, including a state or national professional producer or consultant associations, to: [~~(A)~~](i) offer a qualified program on a geographically accessible basis; and [~~(B)~~](ii) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner. . . . (7) A navigator shall keep documentation of completing the continuing education requirements of this section for two years after the end of the [~~two-year~~] one-year licensing period to which the continuing education applies.	**Policy change:** Removes authority for the commissioner to, by rule, publish a list of designations, whose continuing education requirements can be used to meet navigator licensee CE requirements.
	31A-23b-301. Unfair practices – Compensation – Limit of scope of practice .	
3386-87	(4) A navigator licensed under this chapter is subject to the unfair marketing practices and inducement provisions of [~~Section~~] Sections 31A-23a-402 and 31A-23a-402.5.	**Codifying existing practice:** The proposed change clarifies navigators are subject not only to inducement provisions, but also unfair marketing practices.
	31A-23b-402. Probation – Grounds for revocation.	
3409	(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows: (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under this section; or (b) at the issuance of a new license:	**Technical change:** Corrects references to U.S. Code section.

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and 3424-25	(i) with an admitted violation under 18 U.S.C. ~~[Secs.]~~ Sec. 1033 ~~[and 1034]~~; or (2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. ~~[Secs.]~~ Sec. 1033 ~~[and 1034]~~.	
	31A-25-208. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license – Rulemaking for renewal and reinstatement.	
3518-19	(xxiii) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 ~~[and 1034]~~ and therefore under 18 U.S.C. Sec. 1034 is prohibited from engaging in the business of insurance;	**Technical change:** corrects reference to U.S. Code section, which indicates individuals convicted of a felony involving dishonesty may not engage in the insurance business.
	31A-25-209. Probation –Grounds for revocation.	
3576 and 3591-92	(i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [and 1034]; or (2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. ~~[Secs.]~~ Sec. 1033 ~~[and 1034]~~.	**Technical change:** Corrects references to U.S. Code section.
	31A-26-102. Definitions.	
3602-3631	(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: (A) examination requirement; (B) fingerprint background check requirement; and (C) continuing education requirement; and (c) the adjuster has designated the state, territory, or District of Columbia as the designated 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 District of Columbia described in Subsection (3)(a) does not license adjusters for the line of authority sought, a state, territory, or District of Columbia: (i) in which the adjuster is licensed; (ii) in which the adjuster is in good standing; and	**Policy change:** This new definition of "designated home state" is necessary to allow specifically for licensure of non-resident adjusters from a state that does not license adjusters. The proposed changes are consistent with uniform national standards used by the other states.

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	(iii) the adjuster has designated as the adjuster's designated home state. [~~(2)~~] (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. [~~(3)~~] (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.	
	31A-26-206. Continuing education requirements.	
	(d) (i) A licensee is exempt from the continuing education requirements of this section if: (A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;	**Policy change:** Moves forward the exemption date from continuing education requirements, based on when an individual was first licensed by the Department, from April 1, 1978 to December 31, 1982.
	31A-26-207. Examination requirements.	
3741-49	(4) The requirements of this section only apply to [~~applicants who are natural persons~~] an applicant who is a natural person. (5) The requirements of this section do not apply to [members] : (a) a member of the Utah State Bar[~~.~~]; or (b) an applicant for the crop insurance license class who has satisfactorily completed: (i) national crop insurance services crop adjuster proficiency program; or (ii) the loss adjustment training curriculum and competency testing required by the Federal Crop insurance Corporation Standard Reinsurance Agreement through the Risk Management Agency of the United States Department of Agriculture.	**Policy change:** The proposed change, which requires limited lines licensees that sell federally supported crop insurance to complete certain training, is consistent with uniform national standards adopted by other states and federal requirements.
	31A-26-213. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license – Rulemaking for renewal or reinstatement.	
3852-53	(xxiii) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 [~~and 1034~~] and therefore under 18 U.S.C. Sec. 1034 is prohibited from engaging in the business of insurance;	**Technical change:** corrects reference to U.S. Code section, which indicates individuals convicted of a felony involving dishonesty may not engage in the insurance business.
	31A-26-214. Probation – Grounds for revocation.	
3909 and 3924-5	with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [and 1034]; or (2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Secs.~~] Sec. 1033 [~~and 1034~~].	**Technical change:** Corrects references to U.S. Code section.

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	31A-26-214.5. License lapse and voluntary surrender.	
3939	(1) (a) A license issued under this chapter 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-26-206 before submitting the license renewal application; (iii) submit a completed renewal application as required by Section 31A-26-202; (iv) submit additional documentation required to complete the licensing process as related to a specific license type or license classification; or (v) maintain an active license in [~~a resident~~]the licensee's home state if the licensee is a nonresident licensee.	**Policy change:** In concert with the proposed change in 31A-26-102 (definition section) this specifically allows for licensure of non-resident adjusters from a state that does not license adjusters. The proposed changes are consistent with uniform national standards used by the other states.
	31A-27a-102. Definitions.	
4187-8	(32) As the context requires, "receiver" means the commissioner or his designee, including a rehabilitator, liquidator, or ancillary receiver.	**Technical change:** clarifies that in the context of an insolvent insurer in state receivership, the "receiver" is the commissioner or a person designated as the receiver.
	31A-27a-107. Notice and hearing on matters submitted by the receiver for receivership court approval.	
4261-2 and 4278-9	(1) (a) Upon written request to the receiver, a person shall be placed on the service list to receive notice of matters filed by the receiver. The person shall include in a written request under this Subsection (1)(a) the person's address, facsimile number, or electronic mail address. (b) It is the responsibility of the person requesting notice to: (i) inform the receiver in writing of any changes in the person's address, facsimile number, and electronic mail address; . . . (f) Notice may be provided by first-class mail postage paid, electronic mail, or facsimile transmission, at the receiver's discretion.	**Policy change:** Updates receivership statutes to require claimants to provide contact information including a physical address, fax number OR email and allows the receiver to provide notice electronically, to conform with Utah courts' electronic filing requirements.
	31A-27a-201. Receivership court's seizure order.	
4374-7	(6) (a) An insurer subject to an ex parte seizure order under this section may petition the receivership court at any time after the issuance of a seizure order for a hearing and review of the basis for the seizure order. (b) The receivership court shall hold the hearing and review requested under this Subsection (6) not more than 15 days after the day on which the request is received or as soon thereafter as the court may allow. (c) A hearing under this Subsection (6): (i) may be held privately in chambers; and (ii) shall be held privately in chambers if the insurer proceeded against requests that it be private. (7) (a) If, at any time after the issuance of a seizure order, it appears to the receivership court that a person whose interest is or will be substantially affected by the seizure order did not appear at the hearing and has not been served, the receivership court may order that notice be given to the person. (b) An order under this Subsection (7) that notice be given may not stay the effect of any seizure order previously issued by the receivership court.	**Codifying existing practice:** In the receivership and liquidation chapter, makes technical changes to clarify: 1) that an insurer seized pursuant to an ex parte court order has a right to a hearing to review the basis of the seizure order, not just the seizure order; 2) gives some flexibility to the court to hold said hearing as soon as the court may allow,

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4392-3	(8) Whenever the commissioner makes a seizure as provided in Subsection (2), on the demand of the commissioner, it shall be the duty of the sheriff of a county of this state, and of the police department of a municipality in the state to furnish the commissioner with necessary deputies or officers to assist the commissioner in making and enforcing the seizure order. (9) The commissioner may appoint a receiver under this section. The insurer shall pay the costs and expenses of the receiver appointed.	instead of the current language that it must be held within 15 days; and 3) clarifies that the receiver appointed by the commissioner has its fees paid by the estate of the insurer.
	31A-27a-701. Priority of distribution.	
4453-7	(2) The order of distribution of claims shall be as follows: (c) a Class 3 claim, which: (i) is: . . . (F) an indemnity payment on: (I) a covered claim; or ~~[(II) unearned premium; or]~~ ~~[(III)]~~ (II) a payment for the continuation of coverage made by an entity responsible for the payment of a claim or continuation of coverage of an insolvent health maintenance organization; (G) a claim for unearned premium;	**Technical change:** The proposed change corrects puzzling language that refers to unearned premium in the receivership claim distribution scheme. The change corrects unearned premium from inclusion with indemnity payments to its own subsection within class 3.
	31A-29-106. Powers of Board (HIPUtah)	
4600-05	~~[(3) (a) The board shall on or before September 1, 2004, require the plan administrator or an independent actuarial consultant retained by the plan administrator to redetermine the reasonable equivalent of the criteria for uninsurability required under Subsection 31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.]~~ ~~[(b) The board shall redetermine the criteria established in Subsection (3)(a) at least every five years thereafter.]~~	**Policy change:** Due to the guaranteed issuance of insurance coverage in the ACA for all individuals, HIPUtah terminated coverage for all enrollees. The proposed changes remove sections that are no longer applicable with the winding-up of HIPUtah.
	31A-29-111. Eligibility -- Limitations.	
4688-4690	(5) (a) The board shall establish and adjust, as necessary, health underwriting criteria based on: (i) health condition; and (ii) expected claims so that the expected claims are anticipated to remain within available funding. (b) The board, with approval of the commissioner, may contract with one or more providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting criteria under Subsection (5)(a). ~~[(c) If an individual is denied coverage by the pool under the criteria established in Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage under Subsection 31A-30-108(3).]~~	**Codifying existing practice:** Due to the guaranteed issuance of insurance coverage in the ACA certificates of insurability are no longer necessary.
	31A-29-115. Cancellation -- Notice.	
4706-4713	(1) [~~(a)~~] On the date of renewal, the pool may cancel an enrollee's policy if: [~~(i)~~] (a) the enrollee's health condition does not meet the criteria established in Subsection 31A-29-111(5); and [~~(ii)~~] (b) the pool has provided written notice to the enrollee's last-known address no less than 60 days before	**Codifying existing practice:** Due to the guaranteed issuance of insurance coverage in the ACA

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	cancellation[~~;and~~]. [~~(iii) at least one individual carrier has not reached the individual enrollment cap established in Section 31A-30-110.~~] [~~(b) The pool shall issue a certificate of insurability to an enrollee whose policy is cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the requirements of Subsection 31A-29-111(5) are met.~~]	certificates of insurability are no longer necessary.
	31A-30-102. Purpose statement.	
4741-2	The purpose of this chapter is to: (1) prevent abusive rating practices; (2) require disclosure of rating practices to purchasers; (3) establish rules regarding: (a) a universal individual and small group application; and (b) renewability of coverage; (4) improve the overall fairness and efficiency of the individual and small group insurance market; (5) provide increased access for individuals and small employers to health insurance; and (6) provide an employer with the opportunity to establish a defined contribution arrangement for an employee to purchase a health benefit plan through the ~~Internet portal~~ Health Insurance Exchange created by Section 63M-1-2504.	**Technical change:** Changes term "Internet portal" to "Health Insurance Exchange" to be consistent with 63M-1-2504.
	31A-30-103. Definitions.	
4748	As used in this chapter: (1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with [~~Sections 31A-30-106 and 31A-30-106.1~~]this chapter, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans. (2) "Affiliate" or "affiliated" means ~~[any entity or]~~ a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person. . . . (5) "Carrier" means ~~[any]~~ a person ~~[or entity]~~ that provides health insurance in this state including: (a) an insurance company; (b) a prepaid hospital or medical care plan; (c) a health maintenance organization; (d) a multiple employer welfare arrangement; and (e) ~~[any other]~~ another person ~~[or entity]~~ providing a health insurance plan under this title.	**Codifying existing practice:** For policies issued on or after January 1, 2014, the ACA prohibits certain rating practices. Insurers may no longer rate based on health status or gender. Additionally, the ACA limits how an insurer may rate for geographic area, family status and age.
4797-8	(8) [~~"Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.~~] . . .	**Technical change:** Removes references to conversion policies, which are no longer a requirement effective January 1, 2014.
4825-4828	[~~(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.~~] [~~(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-~~	**Policy change:** Removes the provisions related to enrollment caps in the individual market due to

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	~~110.]~~	guarantee issuance requirements in the ACA effective January 1, 2014.
4841-2	~~[(22) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.]~~	**Codifying existing practice:** Effective January 1, 2014, the ACA prohibits insurers from requiring an individual to be a resident for at least 12 months in order to obtain coverage.
4856-4868	~~[(25) "Uninsurable" means an individual who:~~ ~~(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or~~ ~~(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and~~ ~~(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g) and (h) for which coverage the applicant is applying.~~ ~~(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:~~ ~~(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and~~ ~~(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.]~~	**Policy Change:** Removes the provisions related to enrollment caps in the individual market due to guarantee issuance requirements in the ACA, effective January 1, 2014.
	31A-30-104. Applicability and scope.	
4907-4911 and 4921-2	(5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of ~~[Subsection]~~ Subsections 31A-30-106(1) and 31A-30-106.1(1) with respect to a health benefit plan provided to the trust. . . . (6) Sections 31A-30-106, 31A-30-106.1, 31A-30-106.5, 31A-30-106.7, 31A-30-107, and 31A-30-108, ~~[and 31A-30-111]~~ apply to: (a) any insurer engaging in the business of insurance related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit; and (b) any contract of an insurer, other than a workers' compensation policy, related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit.	**Policy change:** allows a benefit plan provided by a Taft Hartley trust to request waiver from the commissioner from small employer premium rating restriction.
	31A-30-106. Individual premiums – Rating restrictions – Disclosure	
4986-5005	(g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to: (A) implement this chapter; [and] (B) assure that rating practices used by carriers who offer health benefit plans to individuals are consistent with the purposes of this chapter[.]; and (C) promote transparency of rating practices of health benefit plans. (ii) The rules described in Subsection (1)(g)(i) may include rules that:	**Policy change:** Requires commissioner to promulgate rules to promote transparency of rating practices of health benefit plans.

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	(A) assure that differences in rates charged for health benefit products by carriers who offer health benefit plans to individuals are reasonable and reflect objective differences in plan design, not including differences due to the nature of the individuals assumed to select particular health benefit products; and (B) prescribe the manner in which case characteristics may be used by carriers who offer health benefit plans to individuals~~[;]~~. ~~[(C) implement the individual enrollment cap under Section 31A-30-110, including specifying:]~~ ~~[(I) the contents for certification;]~~ ~~[(II) auditing standards;]~~ ~~[(III) underwriting criteria for uninsurable classification; and]~~ ~~[(IV) limitations on high risk enrollees under Section 31A-30-111; and]~~ ~~[(D) establish the individual enrollment cap under Subsection 31A-30-110(1).]~~ ~~[(h) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 325% of that expected for a standard insurable individual with the same case characteristics.]~~	**Policy change:** Removes the provisions related to enrollment caps and underwriting standards for high risk individuals in the individual market due to guarantee issuance requirements in the ACA, effective January 1, 2014.
5039-5042	. . . (4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the carrier's rating methods and practices are: . . . (d) ~~[Records]~~ Except as provided in Subsection (1)(g) or required by PPACA, a record submitted to the commissioner under this section shall be maintained by the commissioner as a protected ~~[records]~~ record under Title 63G, Chapter 2, Government Records Access and Management Act.	
	31A-30-106.7. Surcharge for groups changing carriers.	
5048-5054	(1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered carrier may impose upon a small group that changes coverage to that carrier from another carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could otherwise charge under Section ~~[31A-30-106]~~ 31A-30-106.1. (b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if: (i) the change in carriers occurs on the anniversary of the plan year, as defined in Section31A-1-301; (ii) the previous coverage was terminated under Subsection31A-30-107(3)(e); or (iii) employees from an existing group form a new business ~~[.]~~; and (iii) the surcharge is not applied uniformly to all similarly situated small groups.	**Technical change:** removes incorrect reference to individual rating code section and replaces it with the correct reference to small employer premium rating restriction section.
	31A-30-107. Renewal – Limitations – Exclusions – Discontinuance and nonrenewal.	
5082-5086	(2) A small employer health benefit plan may be discontinued or nonrenewed: (a) for a network plan, if ~~[: (i)]~~ there is no longer any enrollee under the group health plan who lives, resides, or works in: ~~[(A)]~~ (i) the service area of the covered carrier; or ~~[(B)]~~ (ii) the area for which the covered carrier is authorized to do business; [and] or ~~[(ii) in the case of the small employer market, the small employer carrier applies the same criteria the small employer carrier would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or]~~	**Codification of existing practice:** Under the ACA policies are issued on a guaranteed basis.

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	31A-30-108. Eligibility of small employer and individual market.	
5172-5274	(1) (a) ~~[Small employer carriers shall accept residents]~~ A small employer carrier shall accept a small employer that applies for small group coverage as set forth in the Health Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a), and PPACA, Sec. 2702. ~~[(b) Individual carriers shall accept residents for individual coverage pursuant to:]~~ ~~[(i) Health Insurance Portability and Accountability Act, Sec. 2741(a) (b); and]~~ ~~[(ii) Subsection (3)]~~ (b) An individual carrier shall accept an individual that applies for individual coverage as set forth in PPACA, Sec. 2702. (2) (a) ~~[Small]~~ A small employer ~~[carriers]~~ carrier shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer. (b) ~~[Small]~~ A small employer ~~[carriers]~~ carrier may: (i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and (ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i). ~~[(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:~~ ~~(a) the individual is not covered or eligible for coverage:~~ ~~(i) (A) as an employee of an employer;~~ ~~(B) as a member of an association; or~~ ~~(C) as a member of any other group; and~~ ~~(ii) under:~~ ~~(A) a health benefit plan; or~~ ~~(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;~~ ~~(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:~~ ~~(i) the Medicare program established under Title XVIII of the Social Security Act;~~ ~~(ii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or~~ ~~(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;~~ ~~(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:~~ ~~(i) Medicare supplement policy;~~ ~~(ii) conversion option;~~ ~~(iii) continuation or extension under COBRA; or~~ ~~(iv) state extension;~~ ~~(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under Health Insurance Portability and~~	**Codifying existing practice:** Effective January 1, 2014, the ACA requires small employer and individual insurers to accept all persons applying for coverage. The proposed changes remove Utah's prior HIPAA alternative mechanism which is no longer applicable.

~~Accountability Act, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and~~

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

~~(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111(5)(c); or~~

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

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

~~(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.~~

~~(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.~~

~~(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:~~

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

~~(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.~~

~~(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.~~

~~(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.~~

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

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

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

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

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

~~(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in Health Insurance Portability and Accountability Act, Sec. 2741 (a) (b).~~

~~(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the department.~~

~~(7) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:~~

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

~~(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:~~

~~(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small~~

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	~~employer carrier's obligations to existing group contract holders and enrollees; and~~ ~~(B) applies this section uniformly to all employers without regard to:~~ ~~(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or~~ ~~(II) any health status related factor relating to an employee or dependent of an employee.~~ ~~(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.~~ ~~(ii) This Subsection (7)(b) does not:~~ ~~(A) limit the small employer carrier's ability to renew coverage that is in force; or~~ ~~(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.~~ ~~(c) Coverage offered within a service area after the 180 day period specified in Subsection (7)(b) is subject to the requirements of this section.~~]	
	31A-30-207. Rating and underwriting restrictions for health plans in the defined contribution arrangement market.	
5288-9	(2) Notwithstanding ~~[the provisions of]~~ Subsections 31A-30-106.1(9)(b)(ii) and (iii), a carrier offering a defined contribution arrangement in the Health Insurance Exchange under this part~~[: (a)]~~ shall calculate rates based on a family tier rating structure that includes four tiers in compliance with Subsection 31A-30-106.1(9)(b)(i)~~[; and]~~. ~~[(b) may not calculate rates based on a family tier rating structure that includes five or six tiers as described in Subsection 31A-30-106(9)(b)(ii) or (iii).]~~	**Codifying existing practice:** Effective January 1, 2014, the ACA restructures how insurers rate families.
	31A-30-209. Appointment of insurance producers to Health Insurance Exchange.	
5305-5309	(1) A producer may be listed on the Health Insurance Exchange as a credentialed producer producer ~~[for the defined contribution arrangement market in accordance with Section 63M-1-2504]~~, if the producer is designated as ~~[an appointed]~~ a credentialed agent for the ~~[defined contribution arrangement market]~~ Health Insurance Exchange in accordance with Subsection (2).	**Policy change:** Changes the requirement for a producer to be "appointed" by the insurance department to sell on the Health Insurance Exchange, to be "credentialed" by the exchange.
5310-5330	(2) A producer whose license under this title authorizes the producer to sell ~~[defined contribution arrangement health benefit plans may be appointed to the defined contribution arrangement market on]~~ accident and health insurance may be credentialed by the Health Insurance Exchange ~~[by the Insurance Department]~~ and may sell any product on the Health Insurance Exchange, if the producer: ~~[(a) submits an application to the Insurance Department to be appointed as a producer for the defined contribution arrangement market on the Health Insurance Exchange;]~~ ~~[(b) is an appointed agent in accordance with Subsection (3), for products offered in the defined contribution arrangement market of the Health Insurance Exchange, with the carriers that offer a defined contribution arrangement health benefit plan on the Health Insurance Exchange; and]~~ ~~[(c) has completed continuing education for the defined contribution arrangement market that:]~~ ~~[(i) is required by administrative rule adopted by the commissioner; and]~~ ~~[(ii) provides training on premium assistance programs.]~~ (a) is an appointed producer with; (i) all carriers that offer a plan on the Health Insurance Exchange; and	**Technical change:** Updates terminology and procedure related to existing requirement that producers attend Health Insurance Exchange training on an annual basis in order for the Health Insurance Exchange to consider credentialing a producer.

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	(ii) at least one carrier that offers a dental plan on the Health Insurance Exchange; and (b) completes each year the Health Insurance Exchange training that includes training on premium assistance programs. (3) A carrier shall appoint a producer to sell the carrier's products in the defined contribution arrangement market of the Health Insurance Exchange, within 30 days of the notice required in Subsection (3)(b), if: (a) the producer is currently appointed by a majority of the carriers in the Health Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange; and (b) the producer informs the carrier that the producer is: (i) applying to be appointed to the defined contribution arrangement market in the Health Insurance Exchange; (ii) appointed by a majority of the carriers in the defined contribution arrangement market in the Health Insurance Exchange; (iii) willing to complete training regarding the carrier's products offered on [the defined contribution arrangement market in] the Health Insurance Exchange; and (iv) willing to sign the contracts and business associate's agreements that the carrier requires for appointed producers in the Health Insurance Exchange.	
	31A-30-211. Insurer disclosure.	
5348-5352	~~[(1) The Health Insurance Exchange shall provide an employer's producer with the group's risk factor used to calculate the employer group's premium at the time of:~~ ~~(a) the initial offering of a health benefit plan; and~~ (b) the renewal of a health benefit plan. ~~(2) For health benefit plans that renew on or after March 1, 2012:~~] (1) (a)[~~a~~]A carrier shall provide an employer and the employer's producer with premium renewal rates at least 60 days [~~prior to~~] before the group's renewal date for a plan offered under Part 1, Individual and Small Employer Group [~~; and~~]. (b) [~~the~~] The Health Insurance Exchange shall provide an employer and the employer's producer with premium renewal rates at least 60 days [~~prior to~~] before the group's renewal date for a plan offered under Part 2, Defined Contribution Arrangements. [~~(3)~~](2) An insurer does not have to provide additional notice of premium renewal rates to the employer or the employer's producer if the Health Insurance Exchange provides notice in accordance with Subsection [~~(2)~~] (1)(b).	**Codifying existing practice:** Effective January 1, 2014, insurers are no longer allowed to rate based on health risk factors. Therefore, a group risk factor is no longer used to calculate premiums.
	31A-37-501. Reports to commissioner.	
5378-9	(1) A captive insurance company is not required to make a report except those provided in this chapter. (2) (a) Before March 1 of each year, a captive insurance company shall submit to the commissioner a report of the financial condition of the captive insurance company, verified by oath of two of the executive officers of the captive insurance company. (b) Except as provided in Sections 31A-37-204 and 31A-37-205, a captive insurance company shall report: (i) using generally accepted accounting principles, except to the extent that the commissioner requires, approves, or accepts the use of a statutory accounting principle; (ii) using a useful or necessary modification or adaptation to an accounting principle that is required, approved, or accepted by the commissioner for the type of insurance and kind of insurer to be reported upon; and (iii) supplemental or additional information required by the commissioner. (c) Except as otherwise provided:	**Codification of existing practice:** requires that all type of captive insurers submit an annual financial report to the commissioner.

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	(i) [~~an association captive insurance company and an industrial insured group~~] a licensed captive insurance company shall file the report required by Section 31A-4-113; and (ii) an industrial insured group shall comply with Section 31A-4-113.5. (3) (a) A pure captive insurance company may make written application to file the required report on a fiscal year end that is consistent with the fiscal year of the parent company of the pure captive insurance company. (b) If the commissioner grants an alternative reporting date for a pure captive insurance company requested under Subsection (3)(a), the annual report is due 60 days after the fiscal year end. (4) (a) Sixty days after the fiscal year end, a branch captive insurance company shall file with the commissioner a copy of [~~all~~] the reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath by two of the alien captive insurance company's executive officers. (b) If the commissioner is satisfied that the annual report filed by the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed provides adequate information concerning the financial condition of the alien captive insurance company, the commissioner may waive the requirement for completion of the annual statement required for a captive insurance company under this section with respect to business written in the alien jurisdiction. (c) A waiver by the commissioner under Subsection (4)(b): (i) shall be in writing; and (ii) is subject to public inspection.	
	31A-40-203. Covered employee.	
5406	(1) (a) An individual is a covered employee of a professional employer organization if the individual is coemployed pursuant to a professional employer agreement subject to this chapter. (b) An individual who is a covered employee under a professional employer agreement is a covered [~~employer~~] employee, whether or not the professional employer organization provides the notice required by Subsection 31A-40-202(3), the earlier of the day on which: (i) the employee is first compensated by the professional employer organization; or (ii) the client notifies the professional employer organization of a new hire.	**Technical change**: corrects typographical error.
	31A-40-209. Workers' compensation.	
5429 and	(1) In accordance with Section 34A-2-103, a client is responsible for securing workers' compensation coverage for a covered employee. (2) Subject to the requirements of Section 34A-2-103, if a professional employer organization obtains or assists a client in obtaining workers' compensation insurance pursuant to a professional employer agreement: (a) the professional employer organization shall ensure that the client maintains and provides workers' compensation coverage for a covered employee in accordance with Subsection 34A-2-201(1) or (2) and rules of the Labor Commission, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; (b) the workers' compensation coverage may show the professional employer organization as the named insured through a [~~multiple coordinated~~] master policy, if: (i) the client is shown as an insured by means of an endorsement for each individual client; (ii) the experience modification of a client is used; and (iii) the insurer files the endorsement with the Division of Industrial Accidents as directed by a rule of the Labor Commission, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;	**Technical change:** Updates definition of a PEO issued policy from a "multiple coordinated" to a "master" policy to be consistent with definition and terms used by the Utah Labor Department.

5448	(c) at the termination of the professional employer agreement, if requested by the client, the insurer shall provide the client records regarding the loss experience related to workers' compensation insurance provided to a covered employee pursuant to the professional employer agreement; and (d) the insurer shall notify a client if the workers' compensation coverage for the client is terminated. (3) In accordance with Section 34A-2-105, the exclusive remedy provisions of Section 34A-2-105 apply to both the client and the professional employer organization under a professional employer agreement regulated under this chapter. (4) Notwithstanding the other provisions in this section, an insurer may choose whether to issue: (a) a policy for a client; or (b) a [~~multiple coordinated~~] master policy with the client shown as an additional insured by means of an individual endorsement.	
	31A-42-202. Contents of plan.	
5476, 5484-5, 5492 and 5503-4	(2) (a) The plan adopted by the board for the defined contribution arrangement market shall include: (i) parameters an employer may use to designate eligible employees for the defined contribution arrangement market; and (ii) underwriting mechanisms and employer eligibility guidelines: (A) consistent with the federal Health Insurance Portability and Accountability Act; and (B) necessary to protect insurance carriers from adverse selection in the defined contribution market. (b) The plan required by Subsection (2)(a) shall outline how premium rates for a qualified individual in the defined contribution arrangement market are determined, including: (i) the identification of an initial rate for a qualified individual based on: (A) standardized age bands submitted by participating insurers; and (B) wellness incentives for the individual as permitted by federal law; and (ii) the identification of a group risk factor to be applied to the initial age rate of a qualified individual based on the health conditions of all qualified individuals in the same employer group and, for small employers, in accordance with Sections 31A-30-105 and 31A-30-106.1. (c) The plan adopted under Subsection (2)(a) for the defined contribution arrangement market shall outline how: (i) premium contributions for qualified individuals shall be submitted to the Health Insurance Exchange in the amount determined under Subsection (2)(b); and (ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by qualified individuals within an employer group based on each individual's rating factor determined in accordance with the plan. (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting risk between defined contribution arrangement market insurers that: (i) identifies health care conditions subject to risk adjustment; (ii) establishes an adjustment amount for each identified health care condition; (iii) determines the extent to which an insurer has more or less individuals with an identified health condition than would be expected; and (iv) computes all risk adjustments. (e) The board may amend the plan if necessary to: (i) maintain the proper functioning and solvency of the defined contribution arrangement market and the risk adjuster	**Codifying existing practice:** Clarifies the Risk Adjuster Board applies only to defined contribution arrangements.

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	mechanism; (ii) mitigate significant issues of risk selection; or (iii) improve the administration of the risk adjuster mechanism. (3) The board shall establish a mechanism in which the defined contribution arrangement market participating carriers shall submit their plan base rates, rating factors, and premiums to the commissioner for an actuarial review under ~~[the provisions of]~~ Section 31A-30-115 ~~[prior to]~~ the publication of the premium rates on the Health Insurance Exchange.	
	31A-43-102. Definitions.	
5517- 5520 and 5537- 5540	For purposes of this chapter: (1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer is in compliance with ~~[the provisions of]~~ this chapter, based upon the individual's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the stop-loss insurer in establishing attachment points and other applicable determinations in conjunction with the provision of stop-loss insurance coverage. (2) "Aggregate attachment point" means the dollar amount [~~in losses for eligible expenses~~]of covered claims incurred by a small employer plan beyond which the stop-loss insurer incurs liability for [~~all or part of the~~]losses incurred by the small employer plan, subject to limitations included in the contract. (3) "Coverage" means the combination of the employer plan design and the stop-loss contract design. (4) "Expected claims" means the amount of claims that, in the absence of [~~a~~]aggregate stop-loss [~~contract~~]insurance, are projected to be incurred by a small employer health plan using reasonable and accepted actuarial principles.	**Technical change:** Clarifies terms for *covered claims* instead of *eligible expenses*; and removes confusion to reference "losses" instead of "all or part of the losses."
5526- 5531	(5) "Lasering": (a) means increasing or removing stop-loss coverage for a specific individual within an employer group; and (b) includes other practices that are prohibited by the commissioner by administrative rule that result in lowering the stop-loss premium for the employer by transferring the risk for an [~~individual~~]individual's claims back to the employer. (6) "Small employer" means an employer who, with respect to a calendar year and to a plan year: (a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and (b) employs at least two employees on the first day of the plan year. (7) "Specific attachment point" means the dollar amount [~~in losses for eligible expenses~~]of covered claims attributable to a single individual covered by a small employer plan in a contract year beyond which the stop-loss insurer assumes [~~all or part of~~]the liability for losses incurred by the small employer plan, subject to limitations included in the contract. (8) "Stop-loss insurance" means insurance purchased by a small employer for which the stop-loss insurer assumes[~~, on a per loss basis,~~] all loss amounts of the small employer's plan in excess of a stated amount, subject to the policy limit.	**Technical change:** Clarifies lasering is transferring the risk of the individual's claims back to the employer, rather than transferring the risk for an individual.
	31A-43-301. Stop-loss insurance coverage standards.	
5560	(1) A small employer stop-loss insurance contract shall: (a) be issued to the small employer to provide insurance to the group health benefit plan, not the employees of the small employer; (b) use a standard application form developed by the commissioner by administrative rule; (c) have a contract term with guaranteed rates for at least 12 months, without adjustment, unless there is a change in the benefits provided under the small employer's health plan during the contract period;	**Policy change:** lowers aggregate attachment point minimum from 90% of expected claims to 85%.

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5564	(d) include both a specific attachment point and an aggregate attachment point in a contract; (e) align stop-loss plan benefit limitations and exclusions with a small employer's health plan benefit limitations and exclusions, including any annual or lifetime limits in the employer's health plan; (f) have an annual specific attachment point that is at least $10,000; (g) have an annual aggregate attachment point that may not be less than ~~[90%]~~ 85% of expected claims; (h) pay stop-loss claims: (i) incurred during the contract period; and (ii) [~~submitted~~] paid within 12 months after the expiration date of the contract; and (i) include provisions to cover incurred and unpaid claims if a small employer plan terminates. (2) A small employer stop-loss contract shall not: (a) include lasering; and (b) pay claims directly to an individual employee, member, or participant.	**Clarifies existing policy:** Requires stop-loss insurer to consider claims paid within 12 months after the expiration of the stop-loss contract, rather than claims submitted.
	31A-43-302. Stop-loss restrictions – Filing requirements.	
5572-5574	~~[(1) A stop-loss insurer shall demonstrate to the commissioner that the rates associated with specific and aggregate attachment points retained by a small employer group under the insurer's stop-loss plan are actuarially sound.]~~ ~~[(2)~~](1) A stop-loss insurer shall file the stop-loss insurance contract form and [~~rates~~] rate methodology with the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1 before the stop-loss insurance contract may be issued or delivered in the state. [~~(3)~~](2) A stop-loss insurer shall file with the commissioner, annually on or before April 1, in a form and manner required by the commissioner by administrative rule adopted by the commissioner: (a) an actuarial memorandum and certification which demonstrates that the insurer is in compliance with this chapter;[~~and~~] (b) the stop-loss insurer's stop-loss experience [~~(4) Each~~](3) An insurer shall maintain at its principal place of business: (a) a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate the rating methods and practices are: (i) based upon commonly accepted actuarial assumptions; and (ii) in accordance with sound actuarial principles; and (b) a copy of the [~~actuarial certification~~]annual filing required by Subsection [~~(3)~~](2).	**Clarifying existing policy:** Requires stop-loss insurers to file rating methodology with each filing and demonstrate compliance on an annual basis.
	31A-43-303. Stop-loss insurance disclosure.	
5600-5605	A stop-loss insurance contract delivered, issued for delivery, or entered into shall include the disclosure exhibit required by the commissioner through administrative rule, which shall include at least the following information: (1) the complete costs for the stop-loss contract; (2) the date on which the insurance takes effect and terminates, including renewability provisions; (3) the aggregate attachment point and the specific attachment point; (4) ~~[any]~~ limitations on coverage; (5) an explanation of monthly accommodation and disclosure about any monthly accommodation features included in the stop-loss contract;~~[and]~~ (6) a description of terminal liability funding, including[~~:(a)~~] the cost of processing claims before and after the	**Technical change:** Corrects numbering and non-substantive drafter word changes.

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	termination of the contract; and [~~(b)~~](7) maximum claims liability to the employer.	
	31A-43-304. Administrative rules.	
5611-5612	The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to: (1) implement this chapter; ~~[(2) assure that differences in rates charged are reasonable and reflect objective differences in plan design];~~ [~~(3)~~] (2) define lasering practices that are prohibited by this chapter; [~~(4)~~](3) establish the form and manner of the actuarial certification and the annual report on stop-loss experience required by Section 31A-43-302; [~~(5)~~](4) establish the form and manner of the disclosure required by Section 31A-43-303; [~~(6)~~](5) assure the rates associated with the specific attachment points and aggregate attachment points are actuarially sound and are not against the public interest; and [~~(7)~~](6) assure that stop-loss contracts include provisions to cover incurred and unpaid claims if a small employer plan terminates.	**Technical change:** Removes unnecessary rule making requirements.
	53-13-103. Law enforcement officer.	
5637	(1) (a) "Law enforcement officer" means a sworn and certified peace officer who is an employee of a law enforcement agency that is part of or administered by the state or any of its political subdivisions, and whose primary and principal duties consist of the prevention and detection of crime and the enforcement of criminal statutes or ordinances of this state or any of its political subdivisions. (b) "Law enforcement officer" specifically includes the following: (i) any sheriff or deputy sheriff, chief of police, police officer, or marshal of any county, city, or town; (ii) the commissioner of public safety and any member of the Department of Public Safety certified as a peace officer; (iii) all persons specified in Sections 23-20-1.5 and 79-4-501; (iv) any police officer employed by any college or university; (v) investigators for the Motor Vehicle Enforcement Division; (vi) investigators for the Department of Insurance, Fraud Division; [~~(vi)~~] (vii) special agents or investigators employed by the attorney general, district attorneys, and county attorneys; [~~(vii)~~] (viii) employees of the Department of Natural Resources designated as peace officers by law; [~~(viii)~~] (ix) school district police officers as designated by the board of education for the school district; [~~(ix)~~] (x)the executive director of the Department of Corrections and any correctional enforcement or investigative officer designated by the executive director and approved by the commissioner of public safety and certified by the division; [~~(x)~~] (xi) correctional enforcement, investigative, or adult probation and parole officers employed by the Department of Corrections serving on or before July 1, 1993; [~~(xi)~~] (xii) members of a law enforcement agency established by a private college or university provided that the college or university has been certified by the commissioner of public safety according to rules of the Department of Public Safety; [~~(xii)~~] (xiii) airport police officers of any airport owned or operated by the state or any of its political subdivisions; and [~~(xii)~~] (xiv) transit police officers designated under Section 17B-2a-823.	**Policy change:** Changes the status of the 11 fraud investigators from special function law enforcement officers to full law enforcement officers. The change enhances their ability to react as law enforcement and allow the commissioner to move them to law enforcement retirement, which can be supported by the Fraud Division's Budget.

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	63J-1-602.2. List of nonlapsing funds and accounts – Title 31 through Title 45	
5676-5678	(1) Appropriations from the Insurance Department Restricted Account created in Section 31a-3-103, except to the extent that Section 31A-3-103 makes the money received under that section free revenue. ~~(1)~~ (2) Appropriations from the Technology Development Restricted Account created in Section 31A-3-104. . . .	**Policy change:** Adds to the list of nonlapsing accounts the Insurance Department Restricted Account, subject to the cap in 31A-3-103 ($8.5 million).
	Repealer.	
	31A-30-110. Individual enrollment cap.	
	31A-30-111. Limitations on high risk enrollees.	
	Effective date: May 13, 2014, except Section 31A-3-304 (Section that moves up captive insurance company fee date by 20 days to June 1st) is effective on July 1, 2015. And The amendments in Sections 31A-22-605.1; 31A-22-625; and 31A-30-107.5 have retrospective operation to January 1, 2014.	