Utah Insurance Department
2024 Legislative Session, SB0031, 3rd Subst.
Proposed amendments and a brief explanation of each

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

Lines	Amendment text	Nature of change
142-144	**31A-1-103. Scope and applicability of title.** ***** (3) Except as otherwise expressly provided, this title does not apply to: (a) those activities of an insurer where state jurisdiction is preempted by Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended; (b) ocean marine insurance; (c) death, accident, health, or disability benefits provided by an organization [~~if the organization~~]<u>that</u>: (i) has as the organization's principal purpose to achieve charitable, educational, social, or religious objectives rather than to provide death, accident, health, or disability benefits; (ii) does not incur a legal obligation to pay a specified amount; and (iii) does not create reasonable expectations of receiving a specified amount on the part of an insured person; <u>and</u> <u>(iv) is not a health care sharing ministry that provides that a participant make a contribution to pay another participant's qualified expenses with no assumption of risk or promise to pay.</u> (d) other business specified in rules adopted by the commissioner on a finding that:	

	(i) the transaction of the business in this state does not require regulation for the protection of the interests of the residents of this state; or (ii) it would be impracticable to require compliance with this title; (e) except as provided in Subsection (4), a transaction independently procured through negotiations under Section 31A-15-104; (f) self-insurance; (g) reinsurance; (h) subject to Subsection (5), an employee or labor union group insurance policy covering risks in this state or an employee or labor union blanket insurance policy covering risks in this state, if: (i) the policyholder exists primarily for purposes other than to procure insurance; (ii) the policyholder: (A) is not a resident of this state; (B) is not a domestic corporation; or (C) does not have the policyholder's principal office in this state; (iii) no more than 25% of the certificate holders or insureds are residents of this state; (iv) on request of the commissioner, the insurer files with the department a copy of the policy and a copy of each form or certificate; and (v)(A) the insurer agrees to pay premium taxes on the Utah portion of the insurer's business, as if the insurer were authorized to do business in this state; and (B) the insurer provides the commissioner with the security the commissioner considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of Admitted Insurers; (i) to the extent provided in Subsection (6): (i) a manufacturer's or seller's warranty; and (ii) a manufacturer's or seller's service contract; (j) except to the extent provided in Subsection (7), a public agency insurance mutual; or	

176-191	(k) except as provided in Chapter 6b, Guaranteed Asset Protection Waiver Act, a guaranteed asset protection waiver[~~.~~]; or (l) a health care sharing ministry, if the health care sharing ministry: (i) provides to each participant upon enrollment and annually thereafter a written statement of nationwide data from the preceding calendar year that lists the total dollar amount of contributions provided to participants toward qualified expenses; and (ii) includes a written disclaimer, titled "Notice", on or with each application and all guideline materials that states: (A) the health care sharing ministry is not an insurance company; (B) nothing the health care sharing ministry offers or provides is an insurance policy, including the health care sharing ministry's guidelines or plan of operations; (C) participation in the health care sharing ministry is entirely voluntary and no participant is compelled by law to contribute to another participant's expenses; (D) participation in the health care sharing ministry or subscription to any of the health care sharing ministry's services is not insurance; and (E) each participant is always personally responsible for the participant's expenses regardless of whether the participant receives payment for the expenses through the health care sharing ministry or whether this health care sharing ministry continues to operate. *****	***Policy change:*** This amendment requires a health care sharing ministry to provide disclosures to participants in order to be exempt from Title 31A.
Lines	**Amendment text**	**Nature of change**
532-541	**31A-1-301. Definitions.** ***** (48) (a) "Direct response solicitation" means an offer for life or accident and health insurance coverage that allows the individual to apply for or enroll in the insurance coverage on the basis of the offer. (b) "Direct response solicitation" does not include an offer for:	***Technical change:*** Moved from 31A-21-402.

	(i) insurance through an employee benefit plan that is exempt from state regulation under federal law; or (ii) credit life insurance or credit accident and health insurance through a individual's creditor. (c) "Direct response insurance policy" means an insurance policy solicited and sold without the policyholder having direct contact with a natural person intermediary. (49) "Direct response insurance policy" means an insurance policy solicited and sol41without the policyholder having direct contact with a natural person intermediary. ***** (82)(a) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care, including major medical expense coverage. (b) "Health benefit plan" does not include: (i) coverage only for accident or disability income insurance, or any combination thereof; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit-only insurance; (vii) coverage for on-site medical clinics; (viii) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits; (ix) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:	

	(A) limited scope dental or vision benefits; (B) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or (C) other similar limited benefits, specified in federal regulations issued pursuant to Pub. L. No. 104-191; (x) the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of benefits and any exclusion of benefits under any health plan, and the benefits are paid with respect to an event without regard to whether benefits are provided under any health plan: (A) coverage only for specified disease or illness; or (B) fixed indemnity insurance; (xi) the following if offered as a separate policy, certificate, or contract of insurance:	
778-779	(A) Medicare [~~supplemental health insurance as defined under the Social Security Act, 42 U.S.C. Sec. 1395ss(g)(1)~~]supplemental insurance; (B) coverage supplemental to the coverage provided under United States Code, Title 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or (C) similar supplemental coverage provided to coverage under a group health insurance plan; (xii) short-term limited duration health insurance; and (xiii) student health insurance, except as required under 45 C.F.R. Sec. 147.145. *****	***Technical change:*** Updating references to Medicare supplement insurance for consistency throughout the Insurance Code.
815-830	(86) "Health care sharing ministry" means an entity that: (a) is a tax-exempt nonprofit entity under the Internal Revenue Code; (b) limits participants to those who are of a similar faith; (c) facilitates the sharing of a participant's qualified expenses, as defined by the entity, among other participants by:	***Policy change:*** See changes in 31A-1-103.

	(i) matching a participant who has qualified expenses with one or more participants who are able to contribute to paying for the qualified expenses; and (ii) arranging, directly or indirectly, for each contributing participant's contribution to be used to pay for the qualified expenses; (d) requires an individual to make one or more minimum payments or contributions as a condition of one or more of the following: (i) becoming a participant; (ii) remaining a participant; or (iii) receiving a contribution to pay qualified expenses; and (e) in carrying out the functions described in this subsection, makes no assumption of risk or promise to pay any qualified expenses. ***** (121)(a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage: (i) in a setting other than an acute care unit of a hospital; (ii) for not less than 12 consecutive months for a covered person on the basis of: (A) expenses incurred; (B) indemnity; (C) prepayment; or (D) another method; (iii) for one or more necessary or medically necessary services that are: (A) diagnostic; (B) preventative; (C) therapeutic; (D) rehabilitative; (E) maintenance; or (F) personal care; and (iv) that may be issued by: (A) an insurer;	

1080	(B) a fraternal benefit society; (I) a nonprofit health hospital; and (II) a medical service corporation; (D) a prepaid health plan; (E) a health maintenance organization; or (F) an entity similar to the entities described in Subsections [~~(118)(a)(iv)(A)~~] (121)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance. (b) "Long-term care insurance" includes: (i) any of the following that provide directly or supplement long-term care insurance: (A) a group or individual annuity or rider; or (B) a life insurance policy or rider; (ii) a policy or rider that provides for payment of benefits on the basis of: (A) cognitive impairment; or (B) functional capacity; or (iii) a qualified long-term care insurance contract. (c) "Long-term care insurance" does not include:	
1091-1092	(i) a policy that is offered primarily to provide basic Medicare supplement insurance [~~coverage~~]; (ii) basic hospital expense coverage; (iii) basic medical/surgical expense coverage; (iv) hospital confinement indemnity coverage; (v) major medical expense coverage; (vi) income replacement or related asset-protection coverage; (vii) accident only coverage; (viii) coverage for a specified: (A) disease; or (B) accident; (ix) limited benefit health coverage;	***Technical change:*** Updating references to Medicare supplement insurance for consistency throughout the Insurance Code.

	(x) a life insurance policy that accelerates the death benefit to provide the option of a lump sum payment: (A) if the following are not conditioned on the receipt of long-term care: (I) benefits; or (II) eligibility; and (B) the coverage is for one or more the following qualifying events: (I) terminal illness; (II) medical conditions requiring extraordinary medical intervention; or (III) permanent institutional confinement; or (xi) limited long-term care as defined in Section 31A-22-2002. *****	
1125-1126	(124) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended. *****	***Technical change:*** Subsections (124) and (125) have been moved from 31A-22-605 and 620.
1127-1138	(125) (a) "Medicare supplement insurance" means health insurance coverage that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of individuals eligible for Medicare, including a Medicare supplement policy. (b) "Medicare supplement insurance" does not include: (i) a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Sec. 1395 et seq.; (ii) a policy issued under a demonstration project specified in 42 U.S.C. Sec. 1395ss(g)(1); (iii) a Medicare Advantage plan established under Medicare Part C; (iv) an outpatient prescription drug plan established under Medicare Part D; or (v) any health care prepayment plan that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.	

1598-1609	**31A-2-201.2. Evaluation of health insurance market.** (1) (a) Each year the commissioner shall: [~~(a)~~] (i) conduct an evaluation of the state's health insurance market; [~~(b)~~] ~~(ii)~~ report the findings of the evaluation to the [~~Health and Human Services Interim Committee~~] Office of Legislative Research and General Counsel before [~~December 1~~] February 1 of each year; and [~~(c)~~] (iii) publish the findings of the evaluation on the department website. (b) After the president of the Senate and the speaker of the House of Representatives appoint members to the Health and Human Services Interim Committee for the year in which the Office of Legislative Research and General Counsel receives a report under this subsection, the Office of Legislative Research and General Counsel shall provide a copy of the report to each member of the committee. *****	***Policy Change:*** The Department needs a two-month extension of the due date for the annual health insurance market report. The change will give the Department the time needed to satisfy additional report requirements and compile, scrub and verify gathered data.
Lines	**Amendment text**	**Nature of change**
1649-1653	**31A-2-211. Rules and forms during transition period.** ***** [~~(3) The commissioner may issue orders declaring that all or part of a rule in effect 1652 under former Title 31 remains in effect until a date specified under the order, which date may 1653 not be later than June 30, 1989. No rule continued under this subsection may be inconsistent 1654 with other provisions under Title 31A, Insurance Code. Notice of the order shall be given 1655 under Section 31A-2-303.~~] *****	***Codifies practice:*** The Department proposes to eliminate this statute because its notice requirements are already contained in other sections of the Utah Code.
Lines	**Amendment text**	**Nature of change**
1665-1681	**31A-2-215. Consumer education.** ***** (3) (a) Consumer assistance may include [~~explaining~~]: (i) explaining: [~~(i)~~] (A) the terms of a policy;	***Codifies practice:*** The Department's employees assist consumers by attempting to resolve policy disputes. They may testify in proceedings if

	[~~(iii)~~] (B) a policy's complaint, grievance, or adverse benefit determination procedure; and [~~(iii)~~] (C) the fundamentals of self-advocacy. (b) informal efforts to negotiate a resolution of a dispute between a consumer and a licensee. (4) (a) Notwithstanding Subsection [~~(3)(a),~~] (3) and Section 31A-2-216, consumer assistance may not include: (i) commencing an administrative, judicial, or other proceeding against a licensee to obtain specific relief from the licensee for a specific consumer; or (ii) [~~testifying or representing a consumer in any grievance or adverse benefit determination, arbitration~~],[~~judicial, or related proceeding,~~] [~~unless the proceeding is in connection with an enforcement action brought under Section 31A-2-308.~~] otherwise representing a consumer in any administrative, judicial, or other proceeding. (5) Nothing in this subsection prohibits the commissioner from taking enforcement action for violations under Section 31A-2-308. [~~(4)~~] (6) The commissioner may adopt rules necessary to implement the requirements of this section.	subpoenaed. However, due to expense and liability exposure, the Department's employees do not and will not represent consumers in a hearing or proceeding. This amendment clarifies the Department's practice.
Lines	**Amendment text**	**Nature of change**
1686-1719	**31A-2-216. Office of Consumer Health Assistance.** (1) The commissioner shall establish[~~:~~ ~~(a)~~] an Office of Consumer Health Assistance before July 1, 1999[~~; and~~ ~~(b) a committee to advise the commissioner on consumer assistance rendered under this section~~]. (2) The office shall: (a) be a resource for health [~~care~~] insurance consumers concerning health [~~care~~] insurance coverage or the need for such coverage; (b) help health [~~care~~] insurance consumers understand: (i) contractual rights and responsibilities;	***Technical changes.***

	(ii) statutory protections; and (iii) available remedies, including adverse benefit determination processes; (c) educate health [~~care~~] insurance consumers: (i) by producing or collecting and disseminating educational materials to consumers, and health insurers[~~, and health benefit plans~~]; and (ii) through outreach and other educational activities; (d) for health [~~care~~] insurance consumers that have difficulty in accessing their health insurance policies because of language, disability, age, or ethnicity, provide information and services, directly or through referral[~~, such as:~~ ~~(i) information and referral; and~~ ~~(ii) adverse benefit determination process initiation~~]; (e) analyze and monitor federal and state consumer health[~~-related~~] insurance statutes, rules, and regulations; and (f) summarize information gathered under this section and make the summaries available to the public, government agencies, and the Legislature. (3) The office may: (a) obtain data from health [~~care~~] insurance consumers as necessary to further the office's duties under this section; (b) investigate complaints and attempt to resolve complaints at the lowest possible level; and (c) assist, but not testify or represent, a consumer in an adverse benefit determination, arbitration, judicial, or related proceeding, unless the proceeding is in connection with an enforcement action [~~brought~~] under Section 31A-2-308. (4) The commissioner may adopt rules necessary to implement the requirements of this section.	
Lines	**Amendment text**	**Nature of change**

1721-1764	**31A-2-218.1. Section 1332 Waiver Study.** (1) As used in this section: (a) "Secretary" means the secretary of the United States Department of Health and Human Services. (b) "Section 1332 waiver" means a waiver for state innovation under 45 C.F.R. Part 155, Subpart N. (2) The commissioner shall conduct a study to determine the feasibility of a state-based program designed to: (a) lower health benefit plan insurance premiums; and (b) increase stabilization in the market. (3) The commissioner, in the study described in Subsection (2), shall create a proposal for a Section 1332 waiver that includes: (a) a list of provisions the state should seek to waive and the rationale for waiving each provision; (b) data, assumptions, targets, and other information sufficient to determine that the proposed waiver will provide coverage at least as comprehensive as coverage that would be provided absent the waiver; (c) coverage and cost sharing protections that keep premiums at least as affordable as would be provided absent the Section 1332 waiver; (d) actuarial analyses, actuarial certifications, and financial modeling that: (i) support the estimates that the proposal will comply with the comprehensive coverage requirements, the affordability requirement, the scope of coverage requirement, and the federal deficit requirement; and (ii) include: (A) a detailed 10-year budget plan that is deficit-neutral to the federal government; (B) all costs to the state, including administrative costs, and other costs to the federal government; and (C) a detailed analysis regarding the estimated impact of the Section 1332 waiver on health insurance coverage in the state; (e) proposed legislative changes to provide the state authority to	***Policy change:*** This amendment requires the commissioner to conduct a study to determine if a federal waiver can be utilized to reduce an individual's health insurance premium costs.

	implement the proposed waiver; (f) implementation plans with a timeline; (g) categories of covered individuals with high-cost medical conditions who may be reinsured through the proposed waiver, including a recommendation for a multi-year phased-in approach; (h) reinsurance parameters, including co-insurance, attachment points, or limits; (i) set premium reduction targets; (j) a detailed plan for a budget and program implementation; and (k) a complete application for submission to the secretary. (4) To carry out the requirements in Subsections (2) and (3) the commissioner may partner or contract with a person that the commissioner determines is appropriate, subject to Title 63G, Chapter 6a, Utah Procurement Code. (5) On or before November 1, 2024, the commissioner shall submit to the Business and Labor Interim Committee a final written report describing the study described in this section.	
Lines	**Amendment text**	**Nature of change**
1784-1786	**31A-2-308 Enforcement penalties and procedures.** ***** (1)(d) The commissioner may accept or compromise any forfeiture~~[under this Subsection (1) until after a complaint is filed under Subsection (2). After the filing of the complaint, only the attorney general may compromise the forfeiture~~].	***Policy Change:*** The current statute eliminates the right of the Department to control court litigation to which it is a party. Instead, the right to control the litigation is given to the attorney general. This is contrary to the well-established principle that a lawyer's client, not a lawyer, should control the outcome of the litigation. The amendment repeals the attorney general's right to control the outcome.
Lines	**Amendment text**	**Nature of change**

1873-1876	**31A-4-113.5. Filing requirements -- National Association of Insurance Commissioners.** (1) (a) Each domestic, foreign, and alien insurer who is authorized to transact insurance business in this state shall annually file with the NAIC a copy of the insurer's: (i) annual statement convention blank on or before March 1; (ii) market conduct annual statements[~~:~~] on or before the applicable date determined by the NAIC; and [~~(A) on or before April 30, for all lines of business except health; and~~ ~~(B) on or before June 30, for the health line of business; and~~] (iii) any additional filings required by the commissioner for the preceding year. *****	***Technical change.*** Allows for the reporting due date to change if it is changed by the NAIC.
Lines	**Amendment text**	**Nature of change**
1908-1922	**31A-6a-109. Enforcement provisions.** [~~Anyone violating of any of the provisions of this chapter or any rule made pursuant to 1866 the grant of rulemaking authority under this title may be assessed an administrative forfeiture 1867 equal to two times the amount of any profit gained from the violation. In addition an administrative forfeiture may be assessed for each violation not to exceed $1,000 per 1869 violation.~~] (1) If the commissioner finds, as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, that a person has violated any provision of this chapter, the commissioner may take one or more of the following actions: (a) revoke a registration issued under this chapter; (b) suspend, for a specified period of 12 months or less, a registration issued under this chapter; (c) deny an application for a registration under this chapter;	**Policy change:** Under the current statute, the Department does not have the power to revoke, suspend or limit a service contract provider's authority to do business when the provider violates the law. By contrast, the Department has this power for other regulated companies and individuals. The proposed amendment gives the Department the same power for service contract providers.

	(d) assess a forfeiture equal to two times the amount of any profit gained from the violation; or (e) assess an additional forfeiture not to exceed $1,000 per violation. *****	
Lines	**Amendment text**	**Nature of change**
	31A-16-102.6 Mutual insurance holding companies. (1) As used in this section: (a) "Intermediate holding company" means a holding company that: (i) is a subsidiary of a mutual insurance holding company; (ii) directly or through a subsidiary of the holding company, holds one or more subsidiary insurers, including a reorganized mutual insurer; and (iii) if the subsidiary insurers were not held by the holding company, a majority of the voting shares of the subsidy insurers' capital stock would be required under this section to be owned by the mutual insurance holding company. (b) "Majority of the voting shares" means the shares of a reorganized mutual insurer's capital stock that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the reorganized mutual insurer's capital stock for the election of directors and other matters submitted to a vote of the reorganized mutual insurer's shareholders. (2) (a) With the commissioner's approval, a domestic mutual insurer may reorganize by forming a mutual insurance holding company in which: (i) in accordance with the mutual insurance holding company's articles of incorporation and bylaws, the membership interests of the domestic mutual insurer's policyholders become membership interests in the mutual insurance holding company; and (ii) the domestic mutual insurer is reorganized as a domestic stock insurance company.	***Policy change:*** Two years ago the Legislature enacted this statute which provides a process for a mutual insurance company to convert to a stock insurance company. The proposed amendments to this statute further clarify the process and require procedural and substantive protections for a mutual insurer's policy holders before and after conversion.

1949	(b) The commissioner may approve a domestic mutual insurer's reorganization under this subsection (2) if: (i) the domestic mutual insurer's reorganization plan: (A) properly protects the interests of the domestic mutual insurer's policyholders; (B) is fair and equitable to the domestic mutual insurer's policyholders; [~~and~~]	
1953-1954	[~~(C)~~] (C) is approved by a majority of the domestic mutual insurer's policyholders present at any regular or special meeting of policyholders at which a quorum is present; and [~~(C)~~] (D) satisfies the requirements of Subsections 31A-16-103(8) through (10); (ii) the initial shares of the reorganized domestic mutual insurer's capital stock are issued to the mutual insurance holding company or intermediate holding company; and (iii) at all times, the mutual insurance holding company or intermediate holding company owns a majority of the voting shares of the reorganized domestic mutual insurer's capital stock.	
1961-1997	(c) With the commissioner's approval, the articles and bylaws of the mutual insurance holding company may provide for membership in such mutual insurance holding company for policyholders of stock insurers that are or become subsidiaries of the mutual insurance holding company . (d) The domestic mutual insurer must provide its policyholders notice of the reorganization plan and the related member meeting by first-class mail. Any such notice of the reorganization plan must include a copy of the full reorganization plan and all related plan materials. The domestic mutual insurer providing notice of the reorganization plan may satisfy the requirement in this subsection (d) to provide a copy of the full plan of reorganization and all related plan materials by including with a notice of reorganization, a URL link at which the policyholders can access the full reorganization plan and any related materials electronically; provided,	

	however, that the domestic mutual insurer must provide a physical copy of the reorganization plan and all related plan materials upon request from a policyholder. (3) (a) With the commissioner's approval, a domestic mutual insurance company may reorganize by merging its policyholders' membership interests into an existing domestic mutual insurance holding company formed under subsection (2) of this section in which: (i) in accordance with the mutual insurance holding company's articles of incorporation and bylaws, the membership interests of the domestic mutual insurer's policyholders become membership interests in the mutual insurance holding company; and (ii) the domestic mutual insurer is reorganized as a domestic stock insurance company subsidiary of the existing domestic mutual insurance holding company or intermediate holding company. (b) The commissioner may approve a domestic mutual insurance company's reorganization under this subsection (3) if: (i) the domestic mutual insurer's reorganization plan: (A) properly protects the interests of the domestic mutual insurer's policyholders; (B) is fair and equitable to the domestic mutual insurer's policyholders; and (C) satisfies the requirements of Subsections 31A-16-103(8) through (10); (ii) all of the initial shares of the capital stock of the reorganized insurance company are issued to the mutual insurance holding company or intermediate holding company; and (iii) at all times, the mutual insurance holding company or intermediate holding company owns a majority of the voting shares of the reorganized domestic mutual insurer's capital stock.	

	(c) The commissioner may require as a condition of approval such modifications of the proposed merger as the commissioner finds necessary for the protection of the policyholders' interests. (4)	
1998-2008	(a) With the commissioner's approval, a foreign mutual insurer organized under the laws of any other state that would qualify to become a domestic insurer organized under the laws of this state may reorganize by [~~forming a~~]merging its policyholders' membership interests into an existing domestic mutual insurance holding company [~~system~~]formed under subsection (2) of this section in which: (i) in accordance with the mutual insurance holding company's articles of incorporation and bylaws, the membership interests of the foreign mutual insurer's policyholders become membership interests in the mutual insurance holding company; and (ii) the foreign mutual insurer is reorganized as a foreign stock insurance company subsidiary of the existing domestic mutual insurance holding company or intermediate holding company.	
2009	(b) The commissioner may approve a foreign mutual insurer's reorganization under this subsection (4) if: (i) the foreign mutual insurer's reorganization plan: (A) complies with any other law or rule applicable to the foreign mutual insurer; (B) properly protects the interests of the foreign mutual insurer's policyholders; (C) is fair and equitable to the foreign mutual insurer's policyholders; and (D) satisfies the requirements of Subsections 31A-16-103(8) through (10);	
2016	(ii) all of the initial shares of the reorganized foreign mutual insurer's capital stock are issued to the mutual insurance holding company or intermediate holding company; and	

2021 **2041-2042**	(iii) at all times, the mutual insurance holding company or intermediate holding company owns a majority of the voting shares of the reorganized foreign mutual insurer's capital stock. (c) After a [~~merger~~]reorganization contemplated by this subsection (4), the reorganized foreign mutual insurer may: (i) remain a foreign corporation; and (ii) with the commissioner's approval, be admitted to conduct business in this state. (d) A foreign mutual insurer that is a party to a reorganization plan may redomesticate in this state by complying with the applicable requirements of this state and the foreign mutual insurer's state of domicile. [~~(4)~~](5) (a) As a condition of approval, the commissioner may require a mutual insurer to modify the mutual insurer's reorganization plan to protect the interests of the mutual insurer's policyholders. (b) If the commissioner determines reasonably necessary, at the reorganizing mutual insurer's expense, the commissioner may retain a third-party consultant to assist the commissioner in reviewing the mutual insurer's reorganization plan. (c) The commissioner has jurisdiction over a mutual insurance holding company or intermediate holding company organized in accordance with this section. (d) Subject to the commissioner's approval, a reorganized mutual insurer or a stock insurance subsidiary within a mutual insurance company may issue a dividend or distribution to the mutual insurance holding company or intermediate holding company. [~~(5)~~](6) (a) Subject to the provisions of this section, a mutual insurance holding company resulting from the reorganization of a domestic mutual insurer shall be incorporated in accordance with and is subject to the provisions of	

2062-2068	Chapter 5, Domestic Stock and Mutual Insurance Corporations as if it were a mutual insurer. (b) A mutual insurance holding company's articles of incorporation and bylaws are subject to commissioner's approval in the same manner as an insurance company's articles of incorporation and bylaws. [~~(6)~~](7) (a) A mutual insurance holding company is: (i) subject to Chapter 27a, Insurer Receivership Act; and (ii) a party to any proceeding under Chapter 27a, Insurer Receivership Act, involving an insurer that is a subsidiary of the mutual insurance holding company as a result of a reorganization in accordance with this section. (b) In a proceeding under Chapter 27a, Insurer Receivership Act, involving a reorganized mutual insurer, the assets of the mutual insurance holding company are assets of the estate of the reorganized mutual insurer for the purpose of satisfying the claims of the reorganized mutual insurer's policyholders. (c) A mutual insurance holding company may be dissolved or liquidated only by: (i) prior approval of the commissioner; or (ii) court order in accordance with Chapter 27a, Insurer Receivership Act. [~~(7)~~](8) (a) Section 31A-5-506 does not apply to a mutual insurer's reorganization or merger under this section. (b) Section 31A-5-506 applies to demutualization of a mutual insurance holding company. (c) Subsections 31A-5-204 through 31A-5-217.5, Part 3, Subsection 31A-5-420, Subsection 31A-5-505, Subsection 31A-5-507, and Subsection 31A-5-509 shall not apply to a mutual insurance holding company. (d) A mutual insurance holding company shall not be required to include "insurance" in its name under Subsection 31A-5-203.	

	([~~8~~]~~(9)~~ A membership interest in a domestic mutual insurance holding company is not a security under Utah law. *****	
Lines	**Amendment text**	**Nature of change**
2116	**31A-19a-203. Rate filings.** (1) ***** (e) A rate filing is considered filed when it has been received[~~:~~ ~~(i) with the applicable filing fee as prescribed under Section 31A-3-103; and~~ ~~(ii)~~]pursuant to procedures established by the commissioner.	***Codifies practice:*** With the legislature's repeal of the requirement to file escrow fees in Section 31A-19a-209, the Department no longer imposes the filing fee referenced in Section 31A-19a-203(1)(e)(i).
Line	**Amendment text**	**Nature of change**
2181-2188	**31A-19a-209. Special provisions for title insurance.** ***** (2) A title insurer[~~, individual title insurance producer, or agency title insurance producer~~] may not use any rate or other charge relating to the business of title insurance[~~, including rates or charges for escrow~~] that would cause the title insurer [~~insurance company , individual title insurance producer, or agency title insurance producer~~ to[~~:~~ ~~(a) operate at less than the cost of doing the insurance business; or~~ ~~(b)~~]fail to adequately underwrite a title insurance policy.	***Policy change:*** A requirement that a title licensee operate at a profit is not necessary.
Lines	**Amendment text**	**Nature of change**
2205-2207	**31A-20-108. Single risk limitation.** ***** (3) (a) The commissioner may adopt rules, after hearings held with notice provided [under] [~~Section 31A-2-303~~] as required by law, to specify the maximum exposure to which an assessable mutual may subject itself. *****	***Technical change:*** This change is necessitated by the proposed elimination of Section 31A-2-303.
Lines	**Amendment text**	**Nature of change**

	31A-21-316. Electronic notices and documents. (1) As used in this section: (a) "Delivered by electronic means" includes: (i) delivery to an electronic mail address at which a party has consented to receive a notice or document; or (ii) posting on an electronic network or site accessible by way of the Internet, a mobile application, a computer, a mobile device, a tablet, or any other electronic device, together with separate notice of the posting that is provided by: (A) electronic mail to the address at which the party has consented to receive notice; or (B) any other delivery method that has been consented to by the party. (b) (i) "Party" means a recipient of a notice or document required as part of an insurance transaction. (ii) "Party" includes an applicant, an insured, or a policyholder. (c) "Policy document" means a policy, certificate, amendment, or endorsement. (2) Subject to [~~Subsection (4)~~] Subsections (4) and (5), a notice to a party or another document required under applicable law in an insurance transaction or that serves as evidence of insurance coverage may be delivered, stored, and presented by electronic means if it meets the requirements of Title 46, Chapter 4, Uniform Electronic Transactions Act. (3) Delivery of a notice or document in accordance with this section is considered equivalent to any delivery method required under applicable law. (4) [~~Subject to Subsection (5), a~~] A notice or document may be delivered by electronic means by an insurer to a party under this section if: (a) the party has affirmatively consented to that method of delivery and has not withdrawn the consent; (b) the party, before giving consent, is provided with a clear and conspicuous statement informing the party of:	**Policy change:** This amendment allows insurers to electronically deliver policy documents.

	(i) any right or option of the party to have the notice or document provided or made available in paper or another nonelectronic form; (ii) the right of the party to withdraw consent to have a notice or document delivered by electronic means, including: (A) a condition or consequence imposed if consent is withdrawn; (B) when the insurer will make the party's withdrawal effective, during or at the conclusion of the policy term; and (C) the procedure a party is to follow to withdraw consent to have a notice or document delivered by electronic means; (iii) whether the party's consent applies: (A) only to the particular transaction as to which the notice or document must be given; or (B) to identified categories of notices or documents that may be delivered by electronic means during the course of the party's relationship with the insured; and (iv) the means, after consent is given, by which a party may obtain a paper copy of a notice or document delivered by electronic means; and (c) the party: (i) before giving consent, is provided with a statement of the electronic delivery and retrieval method requirements for access to and retention of a notice or document delivered by electronic means; (ii) consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for a notice or document delivered by electronic means as to which the party has given consent; and (iii) is provided a process to update information needed to contact the party electronically[~~.~~];	
2268 **2270**	(d) [~~(5) (a) After~~] after consent of the party is given and if a change in the electronic delivery or retrieval methods creates a substantial risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies, the insurer [~~shall~~]:	

2271	(i) [~~provide~~] provides the party with a statement of: (A) the revised electronic delivery or retrieval methods; and (B) the right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed under Subsection (4)(b)(ii); [~~and~~]	
2274- **2282**	(ii) [~~comply~~] complies with Subsection (4)(b)[~~.~~]; and [~~(b) Failure by an insurer to comply with this Subsection (5) is treated, at the election 2277 of the party, as a withdrawal of consent for purposes of this section.~~] [~~(c) When an electronic mail address provided by the party to facilitate delivery by 2279 electronic means is returned with a message as undeliverable each time electronic delivery is 2280 attempted over a period not to exceed two business days, the party is presumed to have 2281 withdrawn consent for the purposes of this section.~~] [~~(d)] 2283 [(i)~~]	
2283	(e) [~~An~~] an insurer [~~shall file~~] files with the department the consent statement described under Subsection (4)(b), which includes conditions or consequences for a party to revoke the party's consent to conduct an insurance transaction, electronically.	
2286- **2287**	[~~(ii)~~] (i) An insurer shall file the consent statement described in [~~Subsection (5)(d)(i)] 2287~~ Subsection (4)(b) before the insurer uses the consent statement. [~~(iii)~~] (ii) The insurer shall communicate to the party in accordance with Subsection (4)(b) the conditions or consequences for a party to revoke the party's consent.	
2290- **2308**	(5) (a) An insurer may deliver a policy document to a party, by electronic means and without the party's consent to receive the policy document by electronic means, if: (i) the party has not withdrawn the consent described in this Subsection (5);	

2343-2349	(ii) the insurer provides a clear and conspicuous statement in paper form, to the party, informing the party of: (A) the party's right or option to have the policy document provided or made available in paper or another nonelectronic form; (B) the party's right to withdraw consent to the electronic delivery of a policy document, including the procedure a party must follow to withdraw consent to electronic delivery of a policy document; (C) policy documents that the insurer may deliver electronically; (D) the means by which a party may obtain a paper copy of a policy document that the insurer delivered electronically; (E) the electronic delivery and retrieval method requirements for access to and retention of a policy document delivered electronically; and (F) the process to update the party's electronic contact information; and (iii) the party demonstrates the ability to electronically access the information contained in the policy document. (b) This Subsection (5) does not apply to a life insurance policy document. ***** (13) For purposes of this section, an insurer's failure to comply with Subsection (4) or 2344 (5) constitutes a withdrawal of the party's consent. 2345 (14) A party is presumed to have withdrawn consent under this section if the email address the party provides to receive a policy document returns a message stating that the message is undeliverable each time the insurer attempts electronic delivery over a period of up to two business days. *****	
Lines	**Amendment text**	**Nature of change**
2353-2362	**31A-21-402 Definitions.** [~~As used in this part:~~] [~~(1)(a) "Direct response solicitation" means any offer an insurer makes to persons in this state, either directly or through a third party, to effect life or accident and health insurance coverage which enables the individual to~~	***Technical change:*** Moved to 31A-1-301.

	~~apply or enroll for the insurance on the basis of the offer.~~ ~~(b) "Direct response solicitation" does not include:~~ ~~(i) solicitations for insurance through an employee benefit plan exempt from state regulation under preemptive federal law; or~~ ~~(ii) solicitations through an individual's creditor with respect to credit life or credit accident and health insurance.~~ ~~(2)~~] As used in this part, "mass marketed life or accident and health insurance" means the insurance under any individual, franchise, group, or blanket insurance policy offering life or accident and health insurance: (1) that is offered by means of direct response solicitation through: (a) a sponsoring organization; or (ib) the mails or other mass communications media; and (2) under which the person insured pays all or substantially all of the cost of the person's insurance.	
Lines	**Amendment text**	**Nature of change**
	31A-22-401. Prohibited life insurance policy provisions. No life insurance company may issue or deliver any life insurance policy subject to this chapter under Section 31A-21-101 which contains any provision: (1) forfeiting the policy for failure to repay any loan on the policy or to pay interest on the loan while the total indebtedness on the policy is less than its loan value, and in ascertaining the indebtedness due upon policy loans, the interest, if not paid when due, may be added to the principal of those loans and may bear interest at the same rate as the principal; (2) claiming that the policy was issued or became effective more than one year before the original application for the insurance is executed, if the insured would then be rated at an age more than one year younger than his age at the date of his application, unless the aggregate amount of the annual premiums for the whole term of the back-dated period is paid in cash; [~~or~~] (3) allowing assessments or calls to be made upon policyholders[~~.~~] or	***Technical change***

2382-2386	(4) allowing an insurer to cancel or terminate a policy for a reason other than: (a) nonpayment of a premium when due; or (b) as allowed pursuant to Subsection 31A-21-105(2).	
Lines	**Amendment text**	**Nature of change**
2400-2406	**31A-22-605 Accident and health insurance standards.** ***** (2) [~~As used in this section:~~ ~~(a) "Direct-response insurance policy" means an individual insurance policy solicited and sold without the policyholder having direct contact with a natural person intermediary.~~ ~~(b) "Medicare" means the same as that term is defined in Subsection 31A-22-620(1)(e).~~ ~~(c) "Medicare supplement policy" means the same as that term is defined in Subsection 31A-22-620(1)(f).~~ ~~(3)~~]This section applies to all individual and franchise accident and health policies. ***** (5) The commissioner may adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, relating to the following matters: (a) establishing disclosure requirements for insurance policies covered in this section, designed to adequately inform the prospective insured of the need for and extent of the coverage offered, and requiring that this disclosure be furnished to the prospective insured with the application form, unless it is a direct response insurance policy; (b)(i) prescribing caption or notice requirements designed to inform prospective insureds that particular insurance coverages are not Medicare [~~S~~]supplement [~~coverages~~]insurance;	***Technical change:*** Moved to 31A-1-301. ***Technical change:*** Updating references to Medicare supplement insurance for consistency throughout the Insurance Code.

2455- 2457	(ii) applying the requirements of Subsection (5)(b)(i) to all insurance policies and certificates sold to persons eligible for Medicare; and (c) requiring the disclosures or information brochures to be furnished to the prospective insured on direct response insurance policies, upon his request or, in any event, no later than the time of the policy delivery. *****	
Lines	**Amendment text**	**Nature of change**
2488 **2495** **2496** **2500** **2503** **2504**	**31A-22-614. Claims under accident and health policies.** (1) Section 31A-21-312 applies generally to claims under accident and health policies. (2) (a) Subject to Subsection (1), an accident and health insurance policy may not contain a claim notice requirement less favorable to the insured, or an insured's network provider, than one which requires written notice of the claim within 20 days after the occurrence or commencement of any loss covered by the policy. The policy shall specify to whom claim notices may be given. (b) If a loss of time benefit under a policy may be paid for a period of at least two years, an insurer may require periodic notices that the insured continues to have a disability, unless the insured is legally incapacitated. The insured's, or the insured's network provider, delay in giving that notice does not impair the insured's, the insured's network provider, or beneficiary's right to any indemnity which would otherwise have accrued during the six months preceding the date on which that notice is actually given. (3) An accident and health insurance policy may not contain a time limit on proof of loss which is more restrictive to the insured, or the insured's network provider, than a provision requiring written proof of loss, delivered to the insurer, within the following time: (a) for a claim where periodic payments are contingent upon continuing loss, within [~~90~~] 120 days after the termination of the period for which the insurer is liable; or	

	(b) for any other claim, within [~~90~~] 120 days after the date of the loss**.** *****	
Lines	**Amendment text**	**Nature of change**
2517-2543	**31A-22-620 Medicare Supplement Insurance Minimum Standards Act.** (1) As used in this section: (a) "Applicant" means: (i) in the case of an individual Medicare supplement insurance policy, the person who seeks to contract for insurance benefits; and (ii) in the case of a group Medicare supplement insurance policy, the proposed certificate holder. (b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement insurance policy. (c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer. (d) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering, or issuing for delivery in this state, Medicare supplement policies or certificates. ~~[(e)"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.~~ ~~(f) "Medicare Supplement Policy":~~ ~~(i) means a group or individual policy of health insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Sec. 1395~~ ~~et seq., or an issued policy under a demonstration project specified in 42 U.S.C. Sec. 1395ss(g)(1), that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare; and~~	***Technical changes*** ***Technical change:*** Moved to 31A-1-301

2546-2635	~~(ii) does not include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.~~ ~~(g)~~]"Policy form" means the form on which the policy is delivered or issued for delivery by the issuer. ***** (2) (a) Except as otherwise specifically provided, this section applies to: (i) all Medicare supplement <u>insurance</u> policies delivered or issued for delivery in this state on or after the effective date of this section; (ii) all certificates issued under group Medicare supplement <u>insurance</u> policies, that have been delivered or issued for delivery in this state on or after the effective date of this section; and (iii) policies or certificates that were in force prior to the effective date of this section, with respect to requirements for benefits, claims payment, and policy reporting practice under Subsection (3)(d), and loss ratios under Subsection (4). (b) This section does not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers and labor unions, for employees or former employees or a combination of employees and former employees, or for members or former members of the labor organizations, or a combination of members and former members of labor organizations. (c) This section does not prohibit, nor does it apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held out to be Medicare supplement <u>insurance</u> policies or benefit plans.	***Technical changes:*** Updating references to Medicare supplement insurance for consistency throughout the Insurance Code.

	(3) (a) A Medicare supplement insurance policy or certificate in force in the state may not contain benefits that duplicate benefits provided by Medicare. (b) Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate may not exclude or limit benefits for loss incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than: "A condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage." (c) The commissioner shall adopt rules to establish specific standards for policy provisions of Medicare supplement insurance policies and certificates. The standards adopted shall be in addition to and in accordance with applicable laws of this state. A requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this section, may not apply to Medicare supplement insurance policies and certificates. The standards may include: (i) terms of renewability; (ii) initial and subsequent conditions of eligibility; (iii) nonduplication of coverage; (iv) probationary periods; (v) benefit limitations, exceptions, and reductions; (vi) elimination periods; (vii) requirements for replacement; (viii) recurrent conditions; and (ix) definitions of terms. (d) The commissioner shall adopt rules establishing minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement insurance policies and certificates.	

	(e) The commissioner may adopt rules to conform Medicare supplement insurance policies and certificates to the requirements of federal law and regulations, including: (i) requiring refunds or credits if the policies do not meet loss ratio requirements; (ii) establishing a uniform methodology for calculating and reporting loss ratios; (iii) assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance; (iv) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases; (v) establishing a policy for holding public hearings prior to approval of premium increases; (vi) establishing standards for Medicare select policies and certificates; and (vii) nondiscrimination for genetic testing or genetic information. (f) The commissioner may adopt rules that prohibit policy provisions not otherwise specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement insurance policy or certificate. (4) Medicare supplement insurance policies shall return to policyholders benefits that are reasonable in relation to the premium charged. The commissioner shall make rules to establish minimum standards for loss ratios of Medicare supplement insurance policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service basis rather than on a reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.	

	(5)(a) To provide for full and fair disclosure in the sale of [~~Medicare supplement 2252 policies, a Medicare supplement policy~~] Medicare supplement insurance, a Medicare supplement insurance policy or certificate may not be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made. (b) The commissioner shall prescribe the format and content of the outline of coverage required by Subsection (5)(a). (c) For purposes of this section, "format" means style arrangements and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage shall include: (i) a description of the principal benefits and coverage provided in the policy; (ii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and (iii) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions. (d) The commissioner may make rules for captions or notice if the commissioner finds that the rules are: (i) in the public interest; and (ii) designed to inform prospective insureds that particular insurance coverages are not Medicare supplement insurance coverages, for all accident and health insurance policies sold to persons eligible for Medicare, other than: (A) a medicare supplement insurance policy; or (B) a disability income policy. *****	
Line	**Amendment text**	**Nature of change**

2664-2668	**31A-22-802. Definitions.** As used in this part: [~~(1) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor has a disability.~~ ~~(2) "Credit life insurance" means life insurance on the life of a debtor in connection with a specific loan or credit transaction.~~] *****	***Technical change:*** Definitions are currently included in 31A-1-301.
Line	**Amendment text**	**Nature of change**
2697-2698	**31A-22-2002. Definitions.** As used in this part: (1) "Applicant" means: (a) when referring to an individual limited long-term care insurance policy, the person who seeks to contract for benefits; and (b) when referring to a group limited long-term care insurance policy, the proposed certificate holder. (2) "Elimination period" means the length of time between meeting the eligibility for benefit payment and receiving benefit payments from an insurer. (3) "Group limited long-term care insurance" means a limited long-term care insurance policy that is delivered or issued for delivery: (a) in this state; and (b) to an eligible group, as described under Subsection 31A-22-701[~~(2)~~](1). (4)(a) "Limited long-term care insurance" means an insurance policy, endorsement, or rider that is advertised, marketed, offered, or designed to provide coverage: (i) for less than 12 consecutive months for each covered person; (ii) on an expense-incurred, indemnity, prepaid or other basis; and (iii) for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care	***Technical change:*** Correct the statutory reference.

2711	services that is provided in a setting other than an acute care unit of a hospital. (b) "Limited long-term care insurance" includes a policy or rider described in Subsection (4)(a) that provides for payment of benefits based on cognitive impairment or the loss of functional capacity. (c) "Limited long-term care insurance" does not include an insurance policy that is offered primarily to provide: (i) basic Medicare supplement <u>insurance</u> coverage; (ii) basic hospital expense coverage; (iii) basic medical-surgical expense coverage; (iv) hospital confinement indemnity coverage; (v) major medical expense coverage; (vi) disability income or related asset-protection coverage; (vii) accidental only coverage; (viii) specified disease or specified accident coverage; or (ix) limited benefit health coverage.	***Technical changes:*** Updating references to Medicare supplement insurance for consistency throughout the Insurance Code.
Lines	**Amendment text**	**Nature of change**
2782-2786	**31A-23a-105. General requirements for individual and agency license issuance and renewal.** ***** (2)(b) A person described in Subsection (2)(a) shall report to the commissioner: (i) an administrative action taken against the person, including a denial of a new or renewal license application: (A) in another jurisdiction; or (B) by another regulatory agency in this state; [~~and~~] (ii) a criminal prosecution taken against the person in any jurisdiction[~~.~~]<u>; and</u> <u>(iii) a civil action taken against the person in any jurisdiction involving conduct related to a professional or occupational license, certification,</u>	***Policy change:*** The amendment allows the Department to better-monitor licensees for unprofessional misconduct

2794	authorization, or registration, whether or not the person held such license, certification, authorization, or registration. (c) The report required by Subsection (2)(b) shall: (i) be filed: (A) at the time the person files the application for an individual or agency license; and (B) for an action or prosecution that occurs on or after the day on which the person files the application: (I) for an administrative action, within 30 days of the final disposition of the administrative action; or (II) for a criminal prosecution or civil action, within 30 days of the initial appearance before a court; and (ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b). *****	by requiring them to report job-related civil actions against them.
Lines	**Amendment text**	**Nature of change**
2921-2923	**31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.** ***** (5)(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee or license applicant: ***** (iv)[~~fails to pay a final judgment rendered against the person within 60 days after theday on which the judgment became final~~] is more than 60 days past due on an enforceable final judgment; *****	***Policy Change*:** The current statute requires that a final judgement against a licensee be satisfied in 60 days. The amendment allows a licensee to make installment payments on a judgement as long as the payments are not more than 60 days overdue.
Lines	**Amendment text**	**Nature of change**
3030-3055	**31A-23a-119. Special requirements for agency title insurance producers.** (1) As used in this section: (a) "applicable percentage" means:	***Policy change:*** This new statute imposes a capital and net worth requirement for non-affiliated title agencies that matches

	(i) on February 1, 2024, through January 31, 2025, 2.5%; (ii) on February 1, 2025, through January 31, 2026, 3%; (iii) on February 1, 2026, through January 31, 2027, 3.5%; (iv) on February 1, 2027, through January 31, 2028, 4%; and (v) on February 1, 2028, through January 31, 2029, 4.5% (b) "sufficient capital and net worth" means: (i) for a new title entity: (A) $100,000 for the first five years after becoming a new agency title insurance producer; or (B) after the first five years after becoming a new agency title insurance producer, the greater of $50,000, or on February 1 of each year, an amount equal to 5% of the title entity's average annual gross revenue over the preceding two calendar years, up to $150,000; or (ii) for a title entity licensed before May 14, 2019: (A) for the time period beginning on February 1, 2020, and ending on January 31, 2029, the lesser of an amount equal to the applicable percentage of the title entity's average annual gross revenue over the two calendar years immediately preceding the February 1 on which the applicable percentage applies or $150,000; and (B) beginning on February 1, 2029, the greater of $50,000 or an amount equal to 5% of the title entity's average annual gross revenue over the preceding two calendar years, up to $150,000. (2) Before May 1 each year, each agency title insurance producer shall submit a report to the commissioner containing proof satisfactory to the commissioner that the agency title insurance producer had sufficient capital and net worth for the preceding calendar year.	a requirement previously imposed by the Legislature on title agencies that are affiliated businesses. See Utah Code 31A-23a-1001(11) and -1004(1)(e).
Lines	**Amendment text**	**Nature of change**
	31A-23a-406. Title insurance producer's business. (1) As used in this section:	

	(a) "Automated clearing house network" or "ACH network" means a national electronic funds transfer system regulated by the Federal Reserve and the Office of the Comptroller of the Currency. (b) "Depository institution" means the same as that term is defined in Section 7-1-103.	
3064	(c) "Funds transfer system" means the same as that term is defined in Section [~~7-1-103~~] 70A-4a-105. (2) An individual title insurance producer or agency title insurance producer may do escrow involving real property transactions if all of the following exist:	***Technical change:*** The correct statutory citation is Section 70A-4a-105.
3094	****** (g) earnings on money held in escrow may be paid out of the [~~escrow~~] trust account to any person in accordance with the conditions of the escrow; *****	***Technical change:*** Changed to make the statute uniformly refer to "trust account" rather than use "trust account" and "escrow account" interchangeably.
3131	(7) (a) A check from the trust account described in Subsection (2)(d) may not be drawn, executed, or dated, or money otherwise disbursed unless the segregated [~~escrow~~] trust account from which money is to be disbursed contains a sufficient credit balance consisting of collected and cleared money at the time the check is drawn, executed, or dated, or money is otherwise disbursed. (b) As used in this Subsection (7), money is considered to be "collected and cleared," and may be disbursed as follows: ***** (iii) the proceeds of one or more of the following financial instruments may be disbursed on the same day the financial instruments are deposited if received from a single party to the real estate transaction and if the aggregate of the financial instruments for the real estate transaction is less than $10,000:	***Technical change:*** Changed to make the statute uniformly refer to "trust account" rather than use "trust account" and "escrow account" interchangeably.

	(A) a cashier's check, certified check, or official check that is drawn on an existing account at a federally insured financial institution; (B) a check drawn on the trust account of a principal broker or associate broker licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the individual title insurance producer or agency title insurance producer has reasonable and prudent grounds to believe sufficient money will be from the trust account on which the check is drawn at the time of disbursement of proceeds from the	
3150	individual title insurance producer or agency title insurance producer's [~~escrow~~] trust account;	***Technical change:*** Changed to make the statute uniformly refer to "trust account" rather than use "trust account" and "escrow account" interchangeably.
3152	(C) a personal check not to exceed $500 per closing; or (D) a check drawn on the [~~escrow~~] trust account of another individual title insurance producer or agency title insurance producer, if the individual title insurance producer or agency title insurance producer in the escrow transaction has reasonable and prudent grounds to believe that sufficient money will be available for withdrawal from the account upon which the check is drawn at the time of disbursement of money from the [~~escrow~~] trust account of the individual title insurance producer or agency title insurance producer in the escrow transaction; (iv) deposits made through the ACH network may be disbursed on the same day the deposit is made if: (A) the transferred funds remain uniquely designated and traceable throughout the entire ACH network transfer process; (B) except as a function of the ACH network process, the transferred funds are not subject to comingling or third party access during the transfer process;	***Technical change:*** Changed to make the statute uniformly refer to "trust account" rather than use "trust account" and "escrow account" interchangeably.
3164	(C) the transferred funds are deposited into the title insurance producer's [~~escrow~~] trust account and are available for disbursement; and *****	***Technical change:*** Changed to make the statute uniformly refer to "trust account" rather than use "trust account" and "escrow account" interchangeably.

3172 **3174-** **3175**	(v) deposits may be disbursed on the same day the deposit is made if the deposit is made via: (A) the Federal Reserve Bank through the Federal Reserve's Fedwire funds transfer system; or (B) a funds transfer system provided by an association of federally insured depository institutions [~~banks~~]. *****	***Technical change.*** ***Technical change.***
Lines	**Amendment text**	**Nature of change**
3194- **3199**	**31A-23a-413. Title insurance producer's annual report.** An agency title insurance producer [~~and an individual title insurance producer who is not an employee of a title insurer or who has not been designated by an agency title insurance producer~~]shall annually file with the commissioner, by a date and in a form the commissioner specifies by rule, a verified statement of the agency title insurance producer's [~~or individual title insurance producer's~~]financial condition, transactions, and affairs as of the end of the preceding calendar year.	***Codifies practice:*** For the past decades in Utah, there has not been an individual title insurance producer who has not been an employee of a title insurer or who has not been designated by an agency title insurance producer. There are no such individual title insurance producers currently in Utah. Because those individual title insurance producers have not existed and do not exist in Utah, the Department has not received a report from them. The amendment eliminates the requirement that the non-existent individual title insurance producers file a report.
Lines	**Amendment text**	**Nature of change**
3216	**31A-26-301.6. Health care claims practices.** (1) As used in this section: ***** (c) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of: (i) an agreement between the insurer and the provider; (ii) [~~a~~] an accident and health insurance policy or contract of the insurer;	***Technical changes***

3364	or (iii) state or federal law. ***** (15) A [~~health care~~] provider may only seek recovery from the insurer for an amount improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b). (16) (a) An insurer may offer the remittance of payment through a credit card or other similar arrangement. (b) (i) A [~~health care~~] provider may elect not to receive remittance through a credit card or other similar arrangement. (ii) An insurer: (A) shall permit a [~~health care~~] provider's election described in Subsection (16)(b)(i) to apply to the [~~health care~~] provider's entire practice; and (B) may not require a [~~health care~~] provider's election described in Subsection (16)(b)(i) to be made on a patient-by-patient basis. (c) An insurer may not require a [~~health care~~] provider or insured to accept remittance through a credit card or other similar arrangement.	
Lines	**Amendment text**	**Nature of change**
3378-3432	**31A-27a-108.1. Injunctions and orders applicable to a federal home loan bank** (1) As used in this section: (a) "Federal home loan bank" means a federal home loan bank established under the federal Home Loan Bank Act, 12 U. S.C. § 1422. (b) "Insurer-member" means an insurer that is a member as defined in 12 U.S.C. Sec. 1422. (2)(a) Notwithstanding any other provision of this chapter, after the seventh day following the filing of a delinquency proceeding a state court may not prohibit a federal home loan bank from exercising its rights regarding collateral pledged by an insurer-member. (b) A federal home loan bank may repurchase any outstanding capital stock that is in excess of the amount of federal home loan bank stock that	***Policy Change:*** Some of Utah's domestic insurers are members of the Federal Home Loan Bank. As members, they are entitled to borrow funds from the FHLB as needed to fund operations. The proposed statute gives the FHLB the right to obtain collateral pledged by a member-insurer when the member-insurer is in receivership. If the FHLB has this preference in a receivership proceeding, it is able to offer better borrowing terms, thus reducing borrowing costs for the member-insurer.

	the federal loan bank requires the insurer-member to hold as a minimum investment if: (i) the insurer-member is subject to a delinquency proceeding; (ii) the federal home loan bank exercises the federal home loan bank's rights regarding collateral pledged by the insurer-member; (iii) the federal home loan bank, in good faith, determines the repurchase is permissible under applicable laws, regulations, regulatory obligations, and the federal home loan bank's capital plan; and (iv) the repurchase is consistent with the federal home loan banks current capital stock practices that apply to the federal home loan bank's entire membership. (c) Subject to Subsection (2)(d), after a court appoints a receiver for an insurer-member, a federal home loan bank shall provide the receiver a process and establish a timeline for the following: (i) the release of collateral that exceeds the amount required to support secured obligations remaining after any repayment of loans as determined in accordance with the applicable agreements between the federal home loan bank and the insurer-member; (ii) the release of any of the insurer-member's collateral remaining in the federal home loan bank's possession following full repayment of all outstanding secured obligations of the insurer-member; (iii) the payment of fees owed by the insurer-member and the operation of deposits and other accounts of the insurer-member with the federal home loan bank; and (iv) the possible redemption or repurchase of federal home loan bank stock or excess stock of any class that an insurer-member is required to own. (d) An insurer-member shall provide the information described in Subsection (2)(c) within 10 business days after the day on which the receiver requests the information. (d) Upon request from a receiver, a federal home loan bank shall provide	Similar statutes have been passed in 23 states which represent the vast majority of member-insurer borrowers.

	any available options for an insurer-member subject to a delinquency proceeding to renew or restructure a loan to defer associated prepayment fees, subject to: (i) market conditions; (ii) the terms of any loan outstanding to the insurer-member; (iii) the applicable policies of the federal home loan bank; and (iv) the federal home loan bank's compliance with federal laws and regulations. (3) (a) Notwithstanding any other provision of this chapter, the receiver for an insurer-member may not: (i) void any transfer of, or any obligation to transfer, money or any other property arising under or in connection with: (A) any federal home loan bank security agreement; (B) any pledge, security, collateral, or guarantee agreement; or (C) any other similar arrangement or credit enhancement relating to a federal home loan bank security agreement made in the ordinary course of business and in compliance with the applicable federal home loan bank agreement. (b) Notwithstanding Subsection (3)(a), an insurer-member may avoid a transfer if a party to the transfer made the transfer with intent to hinder, delay, or defraud the insurer-member, the receiver for the insurer-member, or an existing or future creditor. (c) This subsection shall not affect a receivers rights regarding advances to an insurer-member in a delinquency proceeding pursuant to 12 C.F.R. Sec.1266.4.	
Line	**Amendment text**	**Nature of change**
	31A-28-113. Credit for assessments paid. (1) (a) A member insurer may offset against its premium tax, income tax, or franchise tax liability to this state an assessment described in Subsection 31A-28-109(2)(b) to the extent of 20% of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid.	***Policy change:*** In 2019, Section 59-7-623 of the tax code was amended to say that insurers can carry forward the income tax credit subject to 31A-28-113. The idea was to have the income tax provisions

Line	Amendment text	Nature of change
3439 3440 3458	(b) To the extent that the offsets described in Subsection (1)(a) exceed [~~premium~~] tax liability, the offsets may be carried forward and used to offset [~~premium~~] tax liability in future years. (c) If a member insurer ceases doing business, all uncredited assessments may be credited against its [~~premium~~] tax liability for the year it ceases doing business. ***** (3) (a) Money shall be paid by the member insurers to the state in a manner required by the State Tax Commission if the money: (i) is acquired by refund in accordance with Subsection 31A-28-109(6) from the association by member insurers; and (ii) has been offset against [~~premium~~] taxes as provided in Subsection (1). (b) The association shall notify the commissioner that the refunds described in Subsection (3)(a) have been made.	follow the premium tax provisions. However, the Insurance Code was not revised to include the carryforward. As a result, under current law, only carriers subject to the premium tax can take advantage of the carryforward. This amendment allows insurers that pay corporate income tax to also take advantage of the carryforward.
Line	**Amendment text**	**Nature of change**
  3485- 3500	**31A-31-108. Assessment of insurers.** ***** (2) To implement insurance fraud provisions, the commissioner may assess an admitted insurer and a nonadmitted insurer transacting insurance under Chapter 15, Part 1, Unauthorized Insurers and Surplus Lines, and Chapter 15, Part 2, Risk Retention Groups Act, an annual fee as follows: (a) $[~~200~~]<u>225</u> for an insurer for which the sum of the Utah consideration is less than or equal to $1,000,000; (b) $[~~450~~]<u>525</u> for an insurer for which the sum of the Utah consideration is greater than $1,000,000 but is less than or equal to $2,500,000; (c) $[~~800~~]<u>925</u> for an insurer for which the sum of the Utah consideration is greater than $2,500,000 but is less than or equal to $5,000,000; (d) $[~~1,600~~]<u>1,850</u> for an insurer for which the sum of the Utah consideration is greater than $5,000,000 but less than or equal to $10,000,000; (e) $[~~6,100~~]<u>7,000</u> for an insurer for which the sum of the Utah consideration is greater than $10,000,000 but less than $50,000,000; and	***Policy change:*** An increase in the assessment fee is necessary to cover the increase costs of operating the Department's Insurance Fraud Division. Those costs include: (a) wage increases to keep up with pay offered by other state law enforcement agencies; and (b) increased bills for prosecutorial legal services from the Attorney General's Office.

	(f) $[~~15,000~~]17,250 for an insurer for which the sum of the Utah consideration equals or exceeds $50,000,000.	
Lines	**Amendment text**	**Nature of change**
3533 **3535-3536**	**31A-35-202. Board responsibilities.** (1) The board shall: ***** (d) recommend to the commissioner action regarding the granting, [~~renewing,~~] suspending, revoking, and reinstating of bail bond agency license. (2) Nothing in Subsection (1)(d) precludes the commissioner from suspending a license under Section 31A-35-504. [~~(2)~~](3) The board may: (a) conduct investigations of allegations of unprofessional conduct on the part of persons or bail bond agencies involved in the business of bail bond insurance; and (b) provide the results of the investigations described in Subsection (2)(a) to the commissioner with recommendations for: (i) action; and (ii) any appropriate sanctions.	***Policy change:*** The current law requires the Bail Bond Oversight Board to recommend to the commissioner the renewal of a bail bond agency's license. However, a renewal application contains confidential financial information to which Board members do not have access. This means that the Board makes a recommendation about a license application without knowing the merits of the application. As a result, the Board's recommendation is simply a rubberstamp of the commissioner's evaluation of an application. The proposed amendment of Subsection (d) eliminates this wasteful process by eliminating the requirement that the Board make a recommendation regarding renewal license applications. ***Codifies practice:*** The current law requires the Bail Bond Oversight Board to recommend to the commissioner the suspension of a bail bond agency's license. However, Section 31A-35-504 requires the commissioner to suspend a license without the Board's recommendation when a bail bond agency has not timely satisfied a

		forfeiture judgment. This amendment is formal recognition of the two different license suspension processes.
Lines	**Amendment text**	**Nature of change**
3554-3561	**31A-35-406. Initial licensing, license renewal, and license reinstatement.** ***** (2) (a) A license under this chapter expires annually effective at midnight on [~~August 14~~]August 31. (b) To renew a bail bond agency license issued under this chapter, on or before [~~July 15~~] August 31, the bail bond agency shall: (i) complete and submit to the department a renewal application that includes certification that: (A) a principal of the agency attended or participated by telephone in at least one entire board meeting during the 12-month period before [~~July 15~~]August 31; *****	***Technical change:*** This amendment changes the due date for a bail bond agency's license renewal application from July 15 to August 31. This will allow a bail bond agency to attend the Bail Bond Oversight Board's July meeting and thereby fulfill a license renewal requirement.
Lines	**Amendment text**	**Nature of change**
3618-3619	**31A-37-202. Permissive areas of insurance.** ***** (7) Notwithstanding Subsection (4), if approved by the commissioner[~~,~~] : (a) a captive insurance company may insure as a reimbursement a limited layer or deductible of workers' compensation coverage[~~.~~] ; and (b) an association captive insurance company that satisfies the requirements of this chapter may provide homeowners' insurance.	***Policy Change:*** Due to natural disasters, homeowners may not be able to obtain homeowners insurance coverages in the traditional market. This amendment allows the creation of an association captive insurance company to provide this coverage.
Lines	**Amendment text**	**Nature of change**
	31A-37-204. Paid-in capital -- Other capital (1) (a) The commissioner may not issue a certificate of authority to a company described in Subsection (1)(c) unless the company possesses and thereafter maintains unimpaired paid-in capital and unimpaired paid-in	***Policy change:*** The intent of this amendment is to make Utah a more attractive domicile for captive insurance companies. The proposed change

3634- 3635	surplus of: ***** (iv) in the case of a sponsored captive insurance company, not less than [~~$500,000~~,] $250,000 of which a minimum of [~~$200,000~~] $50,000 is provided by the sponsor; *****	reduces the minimum amount of capital required to license a sponsored captive insurer in Utah. Other states have already enacted similar requirements.
Lines	**Amendment text**	**Nature of change**
3725- 3727 **3734- 3736** **3739**	**31A-37-502. Examination.** (1) (a) As provided in this section, the commissioner, or a person appointed by the commissioner, [~~shall~~] may examine each captive insurance company [~~in each five-year period~~] at least once every five years. or more frequently if the commissioner determines a more frequent examination is prudent. (b) The five-year period described in Subsection (1)(a) shall be determined on the basis of five full annual accounting periods of operation. (c) The examination is to be made as of: (i) December 31 of the full five-year period; or (ii) the last day of the month of an annual accounting period authorized for a captive insurance company under this section. [~~(d) In addition to an examination required under this Subsection (1), the commissioner, or a person appointed by the commissioner may examine a captive insurance company whenever the commissioner determines it to be prudent~~.] (2) During an examination under this section the commissioner, or a person appointed by the commissioner, shall thoroughly inspect and examine the affairs of the captive insurance company to ascertain all or any combination of the following: (a) the financial condition of the captive insurance company; (b) the ability of the captive insurance company to fulfill the insurance policy obligations of the captive insurance company; and (c) whether the captive insurance company has complied with this	***Codifies practice:*** The proposed amendment makes the statute's language more concise.

3744-3747	chapter. [~~(3) The commissioner may accept a comprehensive annual independent audit in lieu 3385 of an examination:~~] ~~3386 [(a) of a scope satisfactory to the commissioner; and] 3387 [(b) performed by an independent auditor approved by the commissioner.~~] [~~(4)~~] (3) A captive insurance company that is inspected and examined under this section shall pay, as provided in Subsection 31A-37-201(6)(b), the expenses and charges of an inspection and examination.	